North Carolina Division of Social Services
Family Services Manual
Volume V: Adult Services
Chapter III - Adult Placement Services
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"A Model for Excellence in Adult Services Administration and Social Work Practice"

I. Statement of Philosophy and Purpose **5500**

Adult Placement Services are based on the premise that not all aging and disabled adults are able to maintain their own well-being, safety, or security in independent settings. They may not have able and willing family members or other resources to assist them in doing so. They may need more structure and health care or personal care than their family members can provide, even though the family may be able and willing. Given these premises, placement in a substitute living arrangement becomes one of the service options which may be appropriate. Adult Placement Services are the means by which social workers help individuals and their families or representatives determine whether placement can be prevented or is the most desirable option. If placement is the chosen option, Adult Placement Services assist in making arrangements for the client's relocation to a substitute residence, and for adjustment to the new location and maintenance of the placement. It is also the means by which social workers help individuals and their families or representatives determine whether individuals living in facilities can return and live safely in more independent settings in their communities.

This service is often provided during a period of crisis or impending crisis in the life of an aging or disabled person and that of his family. Often, the functional abilities of the individual have deteriorated and the care giving demands have increased. This creates physical emotional and financial challenges for the individual and for his family members and others who are providing care and support to him. Sometimes, a significant life event, such as an illness or change in family structure (death, marriage, birth, relocation) precipitates a consideration of the individual's placement into substitute care. An abusive or neglectful situation may be the precipitator. Improvement in the individual's functioning or in his family's functioning may precipitate a consideration of arranging for the individual to return home. This will still create challenges for the individual and his family.

The social worker's tasks in providing placement services involve attention to the needs of both the individual, and his family and significant other persons. Assistance provided will involve the technical aspects of placement or arranging for other services, as well as attending to the individual's and family's emotional and developmental functioning. It involves providing information to support and enable the individual and family to act, and intervening more actively when the individual and/or family cannot take action. This work should enable positive change for the individual and family to occur. The client and family should be supported, enabled, and empowered to get their needs met through the process.

Because of the likelihood that the individual and family are in a vulnerable or changing situation, it is critical for the social worker to consider several other social work principles in providing this service.

First, it is a voluntary service. Clients who are able to participate in the decision-making process should be aware of all of the long-term in-home and substitute care options (e.g. adult day care, in-home aide, meals, home health, domiciliary and nursing home) that are available for their health status and services recommended by their physicians. They should be given the opportunity to make informed choices about whether placement or other services are desired and, if placement is chosen, what type of appropriate substitute living arrangement is preferred. They should be given the opportunity to choose services with an understanding of possible limitations and consequences of their choices. For clients who are unable to fully participate in the decision-making process, placement should be facilitated by the least intrusive measures. Social workers should support and enable clients to express their wishes to the extent they are able.

Second, the assessment of needs and planning with older and disabled adults should be done in the context of their families and other persons who are significant in their lives. The strengths of clients and their families and support systems should be mobilized to the fullest extent possible. They should be empowered through information, support, and the development of choices to do as much planning and facilitating of services for themselves as is possible. At the same time, the social worker's responsibilities entail making sure all involved parties have the information, skills, resources and emotional stability to take actions. The social worker should take a more active role when these parties are not able to take appropriate action.

Third, within the range of appropriate choices, the settings which are least restrictive to meet the client's needs and which best suit the client's preferred lifestyle should be pursued. If placement is chosen, consideration should be given to substitute living arrangements which are located in the client's community or near his family, if these aspects are important to him. Should the client who is already in a substitute living arrangement or his family express interest in his returning home or to a less restrictive or different setting, the social worker should be prepared to evaluate this option while supporting and enabling the client in working toward this expressed goal.

Fourth, placement in a substitute care residence or leaving a substitute care residence is a significant event in the life of an individual and his family, and is accompanied by changes in emotional functioning and potential growth. The adult will need support and/or counseling to successfully deal with grief about the loss of independence and role identity as well as home and possessions, or may need support in re-establishing independence that was once lost. The adult will also need help in coping with fear and anxiety about the change, feelings of abandonment, and establishing a routine in a new environment. The family should be supported to resolve feelings of guilt and conflicts about relinquishing or resuming care giving responsibilities. There may also be an intensification of earlier unresolved relationship problems, sibling rivalries and symbiotic ties. All involved persons may need support to maintain a sense of self-esteem and identity in the face of change, and may need assistance in maintaining appropriate and supportive family connections.

These state policies and social work practice guidelines adhere to the principles above and are intended to guide social work practice in meeting this same intent. State policies are in the beginning of sections where they pertain, with social work practice guidelines following. State policies are requirements, and are bolded. Social work practice guidelines give recommended ways to carry out the requirements, and additional information which may be useful.

II. Legal Base

The rules and regulations for administration of Adult Placement Services have been adopted by the Social Services Commission on the basis of its authority in G.S. 143B-153; and are filed at 10 NCAC 42A under the provisions of the Administrative Procedures Act. Adult Placement Services are mandated through the North Carolina Social Services Block Grant Plan under the provision of G.S. 143B-l0.

III. Definition

Adult Placement Services are activities necessary to assist aging or disabled individuals and their families or representatives in finding substitute homes or residential health care facilities suitable to their needs when they are unable to remain in their current living situations. Activities include completing an initial screening and assessment while providing counseling to help the individual and his family or representative to determine the need for initial or continued placement; assisting in the process for completing necessary financial applications and medical evaluations; helping to locate and secure placement in a suitable setting and level of care; supporting an individual and his family or representative in the individual's transition from one location to another; and providing counseling and other services to help the individual adjust to the new setting and maintain the placement. Adult Placement Services also include assisting individuals, when requested, to return to more independent settings in the community, or to relocate in more appropriate settings when new levels of care are needed.

IV. Eligibility for Adult Placement Services

A. State Policies

1. Eligibility Criteria

If an individual meets the criteria in the target population below, he is determined to be eligible for Adult Placement Services. Since this service is provided without regard to income, income is not a factor of eligibility for the service and no fees are charged. Adult Placement Services must be provided by every county department of social services.

2. Target Population for Adult Placement Services

An individual is considered to be in the target population if Adult Placement Services are appropriate and desired based on one of the following client needs:

a. Adults who are unable to maintain themselves in their own homes independently or with available community or family supports.

b. Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in relocating due to changes in the level of care needed or other factors indicating that alternative settings may be more appropriate.

c. Adults who are living in substitute homes, residential health care facilities or institutions, and who need assistance in returning to more independent living arrangements in the community.

d. Adults who are living in substitute homes or residential health care facilities, and who need assistance in adjusting to or maintaining their placements due to individual or family problems or a lack of resources.

This target population includes wards for which the director or assistant director of the county department of social services is the guardian.

3. Priority Order of Service

Once an individual is determined to be in the target population, Adult Placement Services are provided in the following order of priority:

a. Adults receiving protective services for whom Adult Placement Services is in their protective services plans.

b. Adults who are at risk of abuse, neglect, or exploitation because: (a) they need assistance with activities of daily living, instrumental activities of daily living, or health care and they have no caregiver, or the caregiver is not able, willing or responsible to provide the amount or type of assistance needed; or (b) they were previously abused, neglected or exploited and the conditions leading to that situation continue to exist.

c. Adults who have problems which place them at risk of losing their current living situations.

d. Adults who do not meet any of the first three priority groups but whose quality of life would be improved with Adult Placement Services.

2. Social Work Practice Guidelines

According to the Family Services Manual, Volume VI, Chapter II, Section 8100 in situations where there is reasonable certainty that the agency will not be able to provide a service, the agency may establish a waiting list. Otherwise, if a requested service cannot be provided promptly, the application for services must be denied. Local policies and procedures governing the agency’s use of a waiting list must be in writing and approved by the county board of social services.

Adult Placement Services must be provided promptly unless a policy governing a waiting list for the service is established. If a waiting list is established, the service must be made available in accordance with the priority order of service listed in IV. A. 3. Above.

V. Screening and Application Process

A. Applying for Adult Placement Services

1. State Policies

When Adult Placement Services are requested, an application must be made in accordance with policies in the Family Services Manual, Volume VI, Chapter II, and Section 8065. An application is not required when the only services provided are information regarding placement options and procedures, referral to a more appropriate resource, or consultation with another service provider. (See Section 5555 for more information on coordination with other service providers.)

The initial request or referral must be screened to determine whether the potential client appears to be in the target population listed in IV.A. (Section 5515). Documentation must reflect how the criteria in the target population were determined to be met.

2. Social Work Practice Guidelines

a. Screening

Depending on the circumstances, the application can be made at the intake setting or at the time the social worker makes a personal contact with the client.

Screening to determine whether an individual falls within a target population for Adult Placement Services includes a review of at least two criteria: the individual's needs and the resources available to the individual to meet those needs. When Adult Placement Services are being requested, there is usually an indication that the individual's needs have become greater than he can manage and/or than his caregivers can manage, or that his needs have lessened and he is ready for a living situation where less assistance is provided.

Screening information, often gathered in an intake setting, is important. This information leads to initial decisions about what service options the client and family initially want to explore and whether and where the client will be entered into the service delivery system. For Adult Placement Services, it is especially critical since these decisions may lead to inappropriate placements of clients who might be maintained in their current settings with services. Lack of appropriate placements or other services also risk the health and safety of clients. The client's needs, and the caregiver's ability to meet those needs, should be briefly screened, to determine what type of service is most likely needed.

<u>For individuals living at home who request or who are referred for initial placement, the following questions will be of assistance in making the screening decision:</u>

-Are the individual's needs for assistance short-term or intermittent, or are they long-term and constant?
-Does the individual have a primary caregiver or others who provide assistance?
-Does the individual have a number of needs which are not being met, placing him at risk?
-What specific needs does the individual have?
-Has the need for assistance on a day-to-day basis increased?
-Is another person required to provide on-going, direct personal care for the individual?
-What are the impacts on the caregiver's time, space, finances, psychological health and physical health?
-Has there been a recent crisis, such as deterioration in the individual's health or that of his caregiver, or a loss in informal supports?
-Does the individual require total supervision due to disorientation or wandering?
-What interventions have already been attempted and what was the outcome?

These types of questions will help the social worker and client or referral source to determine the amount of assistance needed versus the caregiver's ability to assist, which indicates whether a substitute living and care arrangement may be needed. However, further assessment may indicate more appropriate or desired service options than placement. The screening is meant to give an indication of an initial potential service option, and is not meant to replace a thorough assessment of the client and his situation.
Inherent in the screening process is the opportunity to present information to the client or referral source about alternative care and service options. Some options can be screened in or out as potential services, based on client preferences. This process continues with the assessment and service planning.

b. Residency Requirements
Generally, persons who apply for services are residents of North Carolina. However, there may be instances where a person living in another state intends to move to North Carolina and applies for Adult Placement Services. A possible scenario is when a person who needs placement intends to move to North Carolina to live near family members. If the individual meets the criteria in one of the target populations, the social worker may accept the application. The circumstances, however, should allow for services to be provided on a timely basis, according to the Family Services Manual, Vol. VI, Chapter II, or the application should be denied. If the client intends to apply for State/County Special Assistance for Adults or Medicaid to cover the cost of care, the social worker should work closely with income maintenance around residency issues.
If a person with the status of legal alien or refugee or if an illegal alien needs placement services, social workers should refer to the Guide to Alien Eligibility for Federal Programs a copy of which should be in each county department of social services. For further assistance, the Community Services Branch in the Division of Social Services may be contacted.

B. When a Client Refuses Services or is incapacitated
1. State Policies
If an application for Adult Placement Services has been made by a responsible party for an individual who then refuses these services, this refusal must be honored. The social worker must offer other services and accept an application or make a referral for other services as requested by the client. If, however, Adult Placement Services or other services are authorized by one of the following legal surrogate decision-makers or by a court order, the service will be provided as requested:

a. a legally appointed guardian of the person or general guardian;
b. an attorney-in-fact appointed in a Durable Power of Attorney, which grants relevant duties and is in effect; or
c. a health care agent appointed in a Health Care Power of Attorney, which grants relevant duties and is In effect.

If there is reasonable cause to believe during the intake and screening, assessment, service planning or provision of any services that the individual is an abused, neglected or exploited disabled adult in need of protective services, an Adult Protective Services referral must be made. If there are indications that the individual may be incompetent as defined in G.S. 35A-llO1(7) and needs a guardian to facilitate the provision of services, a social worker Will explore options with the referral source, family members or within the agency for facilitating in competency proceedings and the appointment of a guardian.

2. Social Work Practice Guidelines
It is preferable for the client to sign his or her application but, since many individuals in need of placement services are unable to apply another responsible person may apply on the client's behalf. In order of preference, those other persons are a legal guardian (if applicable), attorney-in-fact appointed in a power of attorney or

Health care agent appointed in a health care power of attorney (if applicable and depending on responsibilities granted), a relative or other responsible person.
When another person applies on behalf of a client, that person should be encouraged to make the client aware of the application, if this has not been done already.
Sometimes clients are initially reluctant to accept placement services, and this is understandable given the lifestyle changes and loss of independence which usually accompany placement in a facility. An application for

Adult Placement Services should be viewed by the social worker as an opportunity for further exploration of long term or substitute care with the client and not, in and of itself, a final decision regarding placement. Approaching the application from this framework may help an initially reluctant client to accept an assessment of needs and discussion of service options more readily, and may help the client and family to feel more comfortable in exploring their feelings regarding placement as a substitute care option.

As stated in B. 1. a client's refusal of services must be honored, unless there is a legal surrogate decision-maker or a court order authorizing the service. However, the social worker should try to determine the nature of the refusal, in a sensitive way, so as not to intrude on the person's rights to privacy and self-determination. Even when a client does not allow for a thorough assessment to be done, there may be an opportunity to determine whether the client is just refusing placement in a facility or is refusing all services, and the reasons for the refusal. It is important for the client to be advised if there are potential consequences which may result from the refusal of services, such as having personal and medical needs unattended, so an informed decision can be made. A sensitive approach to the client will often allow for further assessment and relationship building, so that he is able to accept placement or other appropriate services.

If a referral source indicates at intake that the client may be incompetent, there may be other measures to be taken before a service plan can be implemented. An "incompetent adult" in G.S.35A-1 101 means an adult or emancipated minor who lacks sufficient capacity to mange his own affairs or to make or communicate important decisions concerning his person, family, or property whether such lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury, or similar cause or condition. The client's mental status should be assessed closely to determine whether a guardian or other legal measures may be needed to facilitate services (See Section 5525, VI. Assessment and Supportive Counseling, B. 1 .b.).

VI. Assessment and Supportive Counseling

A. State Policies

A thorough assessment must be conducted of the client's situation, including strengths and limitations in the following areas:

1. physical health;
2. mental health;
3. social system;
4. activities of daily living and instrumental activities of daily living;
5. economic and financial circumstances; and
6. environment.

With the exception of the circumstances listed below the client must be seen personally by the social worker as many times as is necessary to do a thorough assessment in the six areas, but a minimum of one time. The personal contact may be in a setting other than the client's home, if the client or others can provide the necessary information for an assessment of the client's living environment, and, if during the course of the assessment, it does not appear that in-home services will be needed or appropriate as an alternative to placement or as an interim service plan.

For the following situations, an assessment must be done as thoroughly as possible with information and resources available to the social worker, without requiring personal contact with the client to complete the assessment.

1. a client who is not currently living in the county in which the application is made;
2. a client who is in an emergency situation, where a placement is needed quickly and personal contact would be a barrier to achieving a quick placement. (Examples of emergency situations may be a natural disaster, closing of a facility, the death or hospitalization of a caregiver, an episode of violence, etc.);
3. a client whose case is being transferred within the agency or referred by another service provider or facility, and an assessment which addresses all six functional areas is available. This assessment must be updated to reflect current information.

Documentation must reflect the reason the client was not seen personally in conducting the assessment.

B. Social Work Practice Guidelines

1. Assessment of the Six Functional Areas

The following are points to consider in assessing the six functional domains for Adult Placement Services.

a. Physical Health

An assessment of the client's physical health is critical when placement or relocation is being considered, since physical health is a strong factor used in determining the appropriate level of care. The FL-2 or MR-2 form, which is completed by the physician, is an important part of the assessment. The information on it should be compared to information gathered by the social worker to see if they are consistent. (For information on FL-2 and MR-2 procedures, see Section 5535, Pre-Placement Procedures, and VIII. A. FL-2, MR-2, and PASARR Procedures.) Often, clients are seeing more than one physician, taking medications prescribed by more than one physician and taking over-the-counter medications. They also sometimes have different perspectives on their illnesses, limitations, and treatments than their physicians. It is important for any discrepancies to be noted and brought to the attention of the physician, with the appropriate consent. In addition, the potential progression of illnesses impacts the consideration of various goals and service options.

b. Mental Health

The client's mental health status not only helps determine whether a facility placement is the most viable option and the level of care, it also determines whether counseling, medications, other resources, or behavior management may be needed during the adjustment phase. For clients who are already residing in facilities, mental health status may be a strong factor in the precipitation or exacerbation of adjustment problems and may indicate whether a return to a more independent setting is possible. The mental health assessment should include cognitive as well as emotional functioning. Any progressive dementing illness should also be noted since it will affect long-term service planning with the client. Judgment and the ability to solve problems are critical areas which affect how planning is done and appropriate services.

The mental health status is one of the criteria for determining whether guardianship or another legal measure will be needed to facilitate services, if there were indications during intake, or if there are indications based on the assessment that the client may be incapacitated or incompetent, a thorough assessment of mental health status is crucial. The social worker may want to administer some screening tests for mental status and spread the assessment over several visits to obtain an accurate picture of mental status. The social worker will also want to analyze the affect of time of day, nutrition, and medications on the client's mental state. Finally, if there is any question about the client's mental status, or when there is a diagnosed mental illness present, a mental health professional should be consulted and/or a mental health evaluation secured.

The FL-2 or MR-2 and PASARR forms also contain some information on mental status which should be compared to the social worker's assessment. (For more information, see Section 5535, VIII. Pre-Placement Procedures, A. FL-2, MR-2, and PASARR Procedures.)

c. Social System

The social system and supports often make the difference in whether a person will need to change living arrangements or can be maintained in the current setting. The social system should be viewed broadly to include family, friends, and informal and formal caregivers or helpers, as well as any person or activity which is of significance to the client. In a domiciliary or nursing home, it includes roommates and significant staff as well. The social system should be assessed not only for assistance given to the client, but also for the dynamics of the system, relationships between family members and others, gaps in the system social stressors, and significant recent changes in the system. The social worker should be aware of social supports which could be strengthened or new supports which could be developed to improve the client's functioning, either independently or in a placement setting. It becomes a crucial area when family members or others are acting formally or informally as decision-makers for the client, particularly when there are disagreements about appropriate care or service planning for the client.

There may also be indications that problems in family functioning will need to be addressed for the client to benefit from services. It will also help to determine how much the family and others can help in arranging placements and in helping with adjustment and whether the family can help residents who are in facilities return to live in independent settings in the community. The dynamics present in a domiciliary or nursing home which affects the client will help determine how to intervene when there are adjustment problems.

Another important area to address is the client's current lifestyle and what type of activities and atmosphere are important to him. This will help in determining which facilities may meet his social needs, if placement becomes the service choice.

d. Activities of Daily Living and Instrumental Activities of Daily Living

The capacity of the client to function independently, as well as the social support available to assist has major implications for whether maintenance in the current living situation is possible. The less able the client is to manage his activities of daily living and instrumental activities of daily living, and the more tenuous or unstable his social support is, the more likely it is that he will need placement. For a client who is already in a facility, the need for greater assistance will help determine if he can remain in the current level of care or in the current

facility, or return to an independent living arrangement. It also is important to discern whether functioning capacities are likely to increase or decrease in the future; if rehabilitation and regaining capacities is possible, or if capacities will remain stable, in-home services or a short-term placement may be a service option rather than long-term care placement. Some of the activities of daily living are addressed on the FL-2, which should be compared and elaborated upon in the social worker's assessment.

e. Economic/Financial Circumstances
The economic status of the client will determine if the client is eligible for any forms of public assistance, which, in some circumstances, will be a determining factor in whether placement is a service option, what level of care can be covered financially, and whether in-home services are an option. It will also help in setting goals and interim service planning, since the client may need assistance in disposing of assets before placement can be achieved. For the client who is already in a facility, the lack of adequate personal funds can contribute to fewer options for outside activities and resources, affecting service planning around adjustment difficulties. The assessment in this area can be somewhat confirmed and supplemented by information in the income maintenance case file, if applicable. (For more information on coordination with income maintenance, see Section 5535, VIII. Pre-Placement Procedures, C. Coordination with Income Maintenance.)

f. Environment
Environment includes the home in which the client is living, as well as the outside grounds and neighborhood. The environment should be assessed for access to rooms, equipment and facilities within the home and outside. Sanitation, fire safety, and hazards should be addressed, as well as neighborhood safety. Particularly if the client is disoriented or confused, the setting should be assessed for potential hazards. The assessment should give consideration to problems in the environment and whether they can be corrected or not. When a client is in a facility, the environment should be assessed to determine if environmental constraints or hazards are contributing to adjustment difficulties.

These six functional areas overlap, and assessment in one area usually yields information pertinent to another area. The object in assessing all six areas is to get a well-rounded perspective on the client and his situation so appropriate goal-setting and service planning can be done. It is important for the assessment to include the client's perspective, as well as that of his caregiver(s) and significant others, and to include observation as well as written materials and discussion.
Consistent with the philosophy of enabling and empowering the client and his family, assessment for strengths should be included. Strengths in any of these areas should be built upon in the service planning process, and this may make the difference in whether the client can remain in his current setting, and how the client will adjust to a new setting. For instance, a client with a strong, independent family system may be able to mobilize the family to provide sufficient care giving so that he can remain at home; a client with good social skills may adjust rely well in a facility by making friends with other residents and relating well to the staff.
If the client is to be placed, a well-rounded assessment can be used to help the client determine appropriate or preferred placement setting(s). Further, it can give the social worker and facility staff information to help the client in adjusting to the placement and obtaining needed resources.

2. Assessment When a Personal Contact is not Required
Although a direct personal contact in the three circumstances described in VI. A. on pages 1 and 2 of this section is not required; the social worker is encouraged to do so when possible, particularly if a thorough assessment has not been done recently. If the client is currently in another county, that county department of social services may initiate or do a complete assessment upon mutual agreement of the two counties. Other options for obtaining the required assessment information are:

-Contacts with the client by telephone or mail;
-Contacts with family members or friends of the client by telephone, mail or personally;
-Written information collected from another facility, hospital, agency, etc. (such as social histories, psychological or physical examination reports, FL-2s);
-Contacts with other social workers or providers by telephone, mail, or personally.

Because client-specific assessment information is normally requested from sources other than the client or person acting responsibly for the client, Consent for the Release of Information will need to be obtained (See Section 5535, VIII. Pre-Placement Procedures, B. Consent for the Release of Information.)
If the client cannot be seen personally during the assessment phase, it is important for the social worker to make every attempt to see the client during the service planning phase or in providing other services. The social worker will want to pay special attention to assure that the relocation and adjustment proceed smoothly. The lack of personal contacts with a client should be an exception in delivery of Adult Placement Services and not the rule.

3. Supportive Counseling
Supportive counseling is inherent in the assessment process and continues throughout service planning, locating and securing a placement (or relocation to independent arrangements in the community), and the adjustment phase. As the social worker gathers information during the assessment process, the clients and family's problems are uncovered, creating opportunities for the social worker to provide counseling or refer the client or family to another professional for counseling. The social worker should not allow the information-gathering process to shortcut opportunities for dealing with the client's and families emotional issues, which are sometimes presented in subtle or non-verbal ways. Because the assessment process includes counseling, it may take more than one contact with the client to complete the assessment and develop a relationship which is conducive to service planning.
The assessment process itself can also create anxiety and fears with the client and his family about a potential placement or relocation, and can elicit unresolved issues which create difficulty for the client. It is important for the social worker to conduct the assessment in a way that does not feel intrusive to the client and family, and that supports and enables them to share information and feelings.

VII. Service Planning

A. State Policies

A service plan must be developed which addresses problems identified during the assessment and which takes into account client and family strengths and goals. The client must be involved in the service planning process as much as he is capable of doing so. The service plan must document activities to meet goals.

B. Social Work Practice Guidelines

1. Counseling

a. Goals and Service Options

Once the assessment is complete and the client's and family's strengths and problems have been identified, sometimes more information is needed about the placement and in-home options that are available, including information about care provided and daily routines in facilities. This also includes potential financial eligibility for services. The client and family can enter the problem-solving process and become more capable of making a decision when fully informed. With more information they can become empowered to cope more effectively with beliefs and emotions which may interfere with their abilities to consider placement as an option. Alternately, clients who are living in facilities may need more information about other service options in communities before they can determine whether returning to a more independent setting is possible.

Counseling around service options may need to be done over a period of time. The client and/or family may not be able to make decisions immediately because of a need to continue gathering information, think more fully about the options, or deal with emotional, financial or family issues. The social worker should be sensitive to this need, and assist with this process as needed.

The discussion of service options should take into account the client's goals. Goals should not be confused with services. For instance, placement is not a goal but a service which may accomplish a number of different goals, such as improving nutritional status, taking medications regularly, increasing opportunities for socialization, etc. Often there are a number of different ways goals can be accomplished. The goals of improving nutritional status, taking medications regularly, and increasing opportunities for socialization might also be met by home health or in-home aides, meals-on-wheels, and transportation, or by adult day care, depending on the specific circumstances and preferences.

There may also be short-term and long-term goals, leading to short and long-term service planning. Goals flow from the problems identified in the assessment. The identification of goals gives the social worker and client a clearer picture of which services are appropriate, what the services are meant to accomplish and a framework for identifying when they are successfully accomplished.

b. Advance Planning and Legal Measures

Counseling with the client and family may also need to include discussion of how to get the client's needs met if he is incompetent or becomes incompetent in the future. This includes planning for health care as well as financial management. If the client seems to be incompetent, a decision should be made about whether in-competency and guardianship procedures should be pursued and if so, what type of guardian is needed. This will depend on factors such as whether there are family members who can arrange for meeting the client's needs, the client's financial situation and medical or legal opinions, if the family and the medical, service and legal communities are in agreement about the client's needs and how to meet them, there may be less intrusive measures that can be taken, such as having a representative payee appointed to manage finances and having the family to facilitate services. If, on the other hand, there is disagreement among family members or the medical, service or legal communities, it may be necessary for guardianship to be pursued to assure that the authority lines are clear and that the client's best interest and/or desires are served. This may also be true if it is anticipated that complex decisions or planning will need to be done for the client, or if there is a complex financial situation if the client is not incompetent, it may be helpful to initiate discussions with the client about how and what decisions he would want to be made in the future. Discussion can include information on r-establishing Advance Directives, such as a Living Will or Health Care Power of Attorney, as well as a durable

Power of Attorney. If the client is interested in these options, the social worker can help facilitate his getting legal advice about these options. (See Appendices L and M for more information on Living Wills and Health Care Powers of Attorney.)

2. Client Involvement in Service Planning

The client should be involved as much as possible in the service planning process. If the client is involved with service planning and believes the plan will help him achieve personal goals, he is more likely to successfully adjust, particularly if he enters a placement arrangement. The social worker should look for opportunities to create choices for the client, even when options appear limited. For instance, if the client's service option seems limited to placement, he still may have choices about which facility to enter, when to move, what belongings to take, what activities will help in adjustment, etc. It is important for the plan to build on client strengths and help him maintain a sense of self-esteem and independence.

3. Family Involvement in Service Planning

The family is often instrumental in service planning, sometimes acting as a surrogate decision-maker for the client, and sometimes facilitating service provision for the client. A decision which personally affects the client also affects the entire family system. The social worker's role is to support the family system in maintaining or strengthening its identity and integrity in the face of change. Caution should be taken not to assume what are seen as familial roles (which may be different in each family).

Sometimes family dynamics interfere with the facilitation of service planning. Family members may disagree on an appropriate service plan for the client, and if the client is somewhat confused or is not able to separate his needs and goals from that of family members, the service planning process becomes difficult. The social worker may need to counsel with the family to resolve the disagreement before service planning with the client can proceed.

The social worker may also have to help the family set limits about what kind and how much assistance they can provide to the client. The social worker may need to help the family know how to communicate their limits to the client, so the client is more fully informed about the possible consequences of his decisions.

4. The Involvement of Surrogate Decision-Makers in Service Planning

When the client has a legal surrogate decision-maker, such as a legal guardian or attorney-in-fact appointed in a Power of Attorney, that person is instrumental in service planning and facilitation. Depending on the responsibilities granted to the surrogate, a service plan may not be able to be implemented without that person's involvement. Therefore, it is important to involve this person early in the process. If there is more than one surrogate decision-maker such as a guardian of the person and guardian of the estate, both persons need to be involved.

Even when there is a legal decision-maker, the client still may be in a position to express his wishes and have input into some aspects of the plan. Finding a way to do this (when the client is able) will help the client to maintain a feeling of control and self-determination. This is also true if the director or assistant director of the county department of social services is the guardian. If the surrogate decision-maker is not a family member, the social worker should also try to be sensitive to the family's feelings and wishes, while helping the legal surrogate to fulfill his responsibilities to the client.

5. Identifying Activities to be Taken and Responsible Parties

When the general direction of the service plan is decided, activities can then be assigned to parties to be implemented, and time frames can be established. This should again involve the client and family as much as possible, to continue the process of enabling and empowering them. They should be allowed to determine what they are able to do and what they need help in doing. With more information and facilitation, they may be able to do much of what is needed.

If the service plan has moved in the direction of in-home or community based services, other social workers or providers should be involved as appropriate in developing the service plan. In some agencies, this may mean transfer of the case to another social worker, which should be done with the knowledge of the client and family.

VIII. Pre-Placement Procedures 5535

A. FL-2, MR-2, and PASARR Procedures State Policies

1. The county department of social services is responsible for facilitating the completion and prior approval of FL-2, MR-2 and Pre-Admission Screening and Annual Resident Review (PASARR) Level I screening forms for clients receiving Adult Placement Services by following procedures in the Admissions Policies in the Rules for the Licensing of Domiciliary Homes; the Aged, Blind and Disabled Medicaid Manual; DMA Administrative Letters; updates issued in the Medicaid Bulletin published by EDS-Federal Corporation; and the North Carolina Pre Admission and Annual Screening Requirements for Nursing Facilities. (See Appendices C, D, E, and F.) The facilitation of FL-2, MR-2 and PASARR Level I form completion can be accomplished by informing the client, family or other representative of procedures for getting the forms completed and following up to see that the procedures are followed. If the client is not able to follow the procedures and has no family or representative able or willing to do so, the social worker must work more directly with the physician or other health care provider to get the form(s) completed. This includes assisting the client in locating resources for completion of the form, including transportation and a physician.

2. Social Work Practice Guidelines
The completion of FL-2, MR-2 and PASARR Level I forms and prior approval of the cost of care for Medicaid are critical when placements are being made.

FL-2 forms (or MR-2 forms when required by the facility) are needed for clients when placement in a domiciliary facility is being planned. (See Appendices A and B for copies of FL-2 and MR-2 forms).
FL-2 forms must be completed and prior approval received for clients when placement in a Medicaid-certified nursing facility is being planned and Medicaid will be the source of payment.
MR-2 forms are required for clients when placement in an ICF-MR facility is being planned. The MR-2 form must be approved only if the payment source is Medicaid.

PASARR Level I screening forms are required to be completed for clients when placement in a Medicaid-certified facility is being planned. When Medicaid will be the source of payment, the PASARR Level I form must be approved along with the FL-2.

The forms may be initiated at intake if screening information indicates placement will likely be needed, in order to expedite the process. However, for situations in which the service plan is less clear, initiation of the FL-2/MR-2IPASARR process too soon can cause unnecessary effort on the part of the social worker, client or family/representative; and the forms may expire before the service plan is set and ready to be implemented. The forms may also have been given to the client family or representative by income maintenance staff. In this case, the social worker's responsibility is to assure that the procedures are being followed to get the forms completed. Advocacy, education and consultation are often appropriate roles for the social worker in facilitating this process. The client, family members or representative may need assistance in understanding the forms, their purpose, and how to get them completed. Some physicians also need assistance in understanding the levels of care and need reinforcement in completing the forms with sufficient medical data to justify the recommended level of care. The social worker often must call the physician to get additional information. If amendments to the FL-2 or MR-2 are authorized by the physician, a copy of the amended form should be sent back to him. Complete information about the requirements and the process for getting the Pre-Admission Screening (PASARR) completed is in Appendix C.

It is important for the agency to set up a system for processing these forms. The system should address roles of services, income maintenance, and clerical staff, with attention to obtaining telephone prior approval; routing, stamping and mailing forms to EDS-Federal Corporation; and assuring that services and income maintenance staff coordinate information and are distributed copies of the forms. Particular attention should be paid to due dates and expiration dates.

B. Consent for the Release of Information

1. State Policies
A consent for the Release of Information must be obtained for every client who is receiving Adult Placement Services. The consent must be obtained according to rules contained in the North Carolina Administrative Code, Subchapter 24B. (See Appendix G)

2. Social Work Practice Guidelines
Adult Placement Services cannot be facilitated without securing client-specific information from medical forms, patient charts, and other sources to do a thorough assessment and determine the services which are needed. The service also cannot be facilitated without releasing client-specific information to facilities where placement is being considered, and sometimes to other service providers when adjustment services, an interim in-home services plan, or plan to return from a facility to an independent setting is being pursued.
As with the application, it is preferable for the person who will receive the services to sign his own consent form. If he cannot, it is preferable for a legal guardian, an attorney-in-fact delegated in a Power of Attorney or health care agent appointed in a Health Care Power of Attorney (depending on responsibilities granted), to sign the consent. Subchapter 24B of the North Carolina Administrative Code - Confidentiality and Access to Client Records (see Appendix G) also allows for someone who is acting responsibly for the client to sign the consent. However, the social worker should be careful when accepting a signature other than the client's signature on the consent form and be reasonably sure the person is acting responsibly for the client. If there is any doubt, the social worker should err on the side of getting the client's signature or pursuing some legal means to facilitate service provision. One option is to give consideration to whether the client is incompetent as defined in G.S. 35A-ll0l (7) (see Section 5520, p. for definition of "incompetent adult") and will need a guardian to facilitate a placement and/or other services. A consent form is not required when information is released or secured pursuant to a court order.
Presuming a person acting responsibly for the client applies for Adult Placement Services at intake, the consent may be signed at that time as well, or the social worker may wait until a personal contact is made with the client. In any case, the consent must be obtained before any information is released or secured.

C. Coordination with Income Maintenance State Policies
Social work staff must inform applicants for Adult Placement Services of the availability of State /County Special Assistance for Adults or Medicaid to cover the cost of care in a facility, and the procedures for making an application if they are interested and have not already applied.
Local agency procedures must be established to assure that FL-2, MR-2, and PASARR forms (Level I screening or notice of final determination) are shared among income maintenance and social work staff when they have mutual clients.
The social worker must coordinate with income maintenance staff regarding the eligibility of clients receiving Adult Placement Services, and must assist the client, family or representative in following procedures to establish eligibility for income maintenance programs as needed to facilitate placement or other services.

2. Social Work Practice Guidelines
The establishment of eligibility for State/County Special Assistance for Adults or Medicaid is an integral part of service provision for clients who are entering placements and who need assistance to cover the cost of care. Although the income maintenance caseworker is responsible for establishing eligibility, it is sometimes necessary for the social worker to help the client or family understand and carry out steps to get eligibility established. This might be as simple as facilitating FL-2 completion or gathering required documents, or as complex as assistance with financial planning.

The social worker should not attempt to interpret eligibility policies to the client and family but should refer them back to the appropriate income maintenance staff. The social worker can, however, work directly with income maintenance staff to see if there are specific areas where the client needs assistance, and can then work

with the client on those areas. This should be coordinated carefully to assure that nothing is done which would create a problem in determining eligibility.

When Medicaid applicants are being placed in nursing facilities, it is critical to the county's Medicaid application processing that the FL-2/PASARR process and the placement be accomplished as soon as possible and that the income maintenance caseworker be kept advised of the person's status. Some Medicaid applications cannot be approved until the person has been placed and prior approval granted, so it is important to advise the income maintenance caseworker immediately when prior approval is granted and when the client is placed so the Medicaid application can promptly be disposed. Failure to inform the income maintenance caseworker could result in the application pending unnecessarily which may negatively affect the county's performance in application processing and result in the county having to pay remedial fines under the terms of the Alexander v. Flaherty court order.

IX. Locating a Bed and Securing Placement

A. Locating a Bed

1. State Policies
a. Social workers in the county departments of social services are responsible for assisting clients who are receiving Adult Placement Services and their families or representatives to locate available beds in substitute homes, residential health care facilities, or independent housing in the community with services and charges suitable to their needs.
b. County departments are not allowed to make referrals to or participate in plans for placing individuals in domiciliary homes, nursing facilities, or any other facility placement arrangements which do not comply with the Civil Rights Act of 1964, or to provide Adult Placement Services to individuals residing in those homes or facilities. (For ways to determine compliance, see 2.d., pages 3 and 4 of this section.)
c. If the social worker cannot determine compliance with the Civil Rights Act of 1964, referrals, planning for placement and services to individuals in those homes or facilities must not be provided.

2. Social Work Practice Guidelines
a. Further Assessment of Client/Family Preferences
Upon deciding that placement is an appropriate service, further assessment is needed to determine which substitute living arrangements can accommodate the client's needs and preferences. This process can and usually does begin at intake and continues throughout the service delivery process. It is important that the search for a bed in an appropriate facility does not hamper the assessment and service planning process and does not inadvertently imply that a decision regarding placement has been made when a decision may not have been made.
The FL-2 or MR-2 will indicate the appropriate level of care.
Beyond that, the client and family may also have preferences regarding accommodations. Assessment should be done regarding the client's lifestyle, the things that are important for the client to feel significant and safe, how the family intends to be involved in the client's care once placed, and resources that may be needed to support a placement. One decision which will also affect preference is whether this is a short-term or long-term placement arrangement. Another issue might be the client's preferences regarding medical treatment and whether there are Advance Directives in place, since some facilities' philosophies and admissions criteria will not allow for refraining from active medical treatment.

b. Providing Information Regarding Facilities
Some clients and their families may already know the facilities where they are interested in pursuing available beds. In this case, their preferences should be documented, and the social worker should assist them in facilitating a placement arrangement in a facility of their choice. In other cases, the client and family may need more information to make a decision.
At a minimum, it is useful for the social worker to compile a list of the local facilities to share so the client and family will be well- informed about all the available options. Another method of sharing information about facilities is to collect photographs, house rules, brochures, etc. about the facilities to share, with the agreement of the administration of the facilities. These materials help to personalize the facilities, and give information which may be important to clients such as smoking and visitation policies, services offered, access to resources and activities, etc. It is important to give factual information and avoid favoritism among facilities.
Clients and their families should be encouraged to visit facilities, review their policies and license, and ask questions of facility staff and residents about issues that are important to them. The social worker may need to assist the client and family in knowing the types of things to observe and what to ask, and to assist in weighing the pros and cons of facilities in relation to the client's needs and preferences. The social worker may also need to facilitate clients' and families' visits to facilities, serving as liaison and also arranging for transportation when needed. In any case, the client and family should be assisted in whatever ways seem appropriate to make fully informed choices. In situations where a client does not have family or others to assist, the social worker may need to be more directives in helping the client choose appropriate facilities.

The social worker needs to remain fully informed about available facilities. In order to be able to fully assist a client and family to know the various options, social workers should keep in contact with their peers in surrounding counties, communicating about available beds in facilities. The Recipient and Provider Services Section of the Division of Medical Assistance Section also keep a Central Bed Registry for nursing facilities to voluntarily call when they have vacancies. The can be contacted Tuesday through Friday for any vacancies which have been reported. This number is 1-800-662-7547.

c. Providing Client-Specific Information to Facilities

Upon determining client and family preferences regarding facilities, it may be necessary for the social worker to actively make referrals to those facilities. Consent for the Release of Information is needed in order to do so. The FL-2 or MR-2 and PASARR, when necessary, are usually primary information sources for facilities to consider accepting a client. In addition, the social worker may want to add to the medical information by including portions of the assessment or other information which may be available, such as a social history. Staff in potential facilities should be given all factual information about the client which may affect a successful placement, such as lifestyle preferences, mental health status, family involvement, and habits. It is counterproductive not to inform potential facility staff of challenging behaviors the client may have; the behaviors should be described factually without any judgment on the part of the social worker. If there are behaviors which may cause difficulty for facility staff, the social worker should be proactive about offering post-placement adjustment services or helping to determine other resources which may help facilitate a successful adjustment.

d. Civil Rights Compliance by Facilities

County departments of social services are not able to make referrals or plan for clients' placements in facilities which are not in compliance with the Civil Rights Act of 1964. They are also not able to provide other Adult Placement Services, such as adjustment services, to clients living in those facilities, since the facilities would benefit indirectly through service to those clients. Most domiciliary and nursing homes do comply; however, there are a few which do not choose to do so. Normally income maintenance and/or social work staff in the county department of social services know which facilities are in compliance because they are certified to accept Medicaid or are able to accept Special Assistance. If staff is unsure, the following procedures should be used.

The Assistance Payments Branch in the Public Assistance Section of the Division of Social Services periodically compiles a list of domiciliary homes and mental health facilities which have signed the Civil Rights Statement of Compliance, and keeps copies of the signed statements. These lists are available as part of the State/County Special Assistance for Adults Manual if there is any question about whether a domiciliary home or mental health facility is in compliance, the Assistance Payments Branch can be contacted at (919) 733-9370, or at 325 N. Salisbury Street, Raleigh, NC 27603-5905. The Adult Homes Specialist is also a resource, as the Civil Rights Statement of Compliance is collected routinely as part of the licensing and monitoring process, although compliance is not required for licensure.

Nursing homes which are Medicaid-certified or Medicare-certified must comply with the Civil Rights Act of 1964 in order to be certified. Their certification should be posted in the facility with the license. The Certification Section of the Division of Facility Services also has a listing of certified facilities and may be contacted for this information at (919) 733-7461 or P. 0. Box 29530, Raleigh, NC 27626-0530.

In addition to the procedures above, the inclusion of a statement of compliance with the Civil Rights Act of 1964 in the home or facility's admissions policies will indicate compliance.

B. Securing Placement State Policies

When an available and appropriate placement for a client has been located, the social worker will assist the client and his family or representative in planning for and facilitating the admissions process. If the client, family or representative is not able or willing to follow admissions procedures, the social worker will provide more direct assistance as needed to facilitate the placement.

The social worker must coordinate with income maintenance staff (if applicable) to assure that eligibility for State/County Special Assistance for Adults or Medicaid is established, assure that there is an understanding between the facility and client about how payment will be made, or assist the client in making alternate arrangements prior to the date of placement.

2. Social Work Practice Guidelines

a. Admissions Planning and Counseling

Depending on the client's circumstances and the involvement of family members or others, the social worker may need to assist the client in making final preparations to move. This can include when to move (depending on the facility's flexibility), what belongings to take, how or whether to dispose of other belongings, and payment arrangements. The social worker may need to help plan or arrange for transportation for the actual move, and to more directly assist or arrange for someone to help in packing. This is an important time for the social worker to help the client see where he has choices, and to help him maintain a sense of self-esteem and independence. If family members are involved, one of the tasks may be to help the family recognize ways in which the client can remain independent The client may also want or need more information at this time about daily routines in the facility and house rules, in addition to needing reassurance and counseling around feelings of fear, anxiety or abandonment Especially if there has been a delay in finding a placement the social worker may need to remind the client of how the decision was made for the client to enter a placement arrangement. When the actual placement is being planned unresolved problems among family members may be reactivated, creating a need for the social worker to provide assistance to the entire family so the client can make a successful move. The social worker should recognize the family's efforts to provide care for the client, and help to frame the placement in a way that it can be seen as a positive change for the client's and family's well-being. The social worker will also want to help the family determine ways in which they can remain actively and appropriately involved with the client in his new home.

b. The Admissions Process

The social worker should assure that the client has someone to help with the actual move and with signing the necessary admissions documents, if he is unable to do so. This should also include helping the client to understand what the documents mean. If the family or representative cannot help the client read or understand the documents, the social worker should do so.

Staff of county departments of social services should not co-sign admission agreements without legal authorization to do so. Even when the agency has legal authorization (such as the client's guardianship or power of attorney), the social worker should exercise caution in signing admissions documents to assure that the agency is not obligated to any terms that are not to the client's benefit or would create financial or other obligations that are un agreeable to the agency. The first option to consider when a co-signature is requested is to see if there is a family member, guardian, attorney-in-fact named in a Power of Attorney, or health care agent named in a Health Care Power of Attorney, who can co-sign the agreement. In negotiating placement arrangements for an adult who has not been adjudicated incompetent and who has no other person to co-sign the agreement, the following guidelines may also be used within the limits of local agency policies:

(1) Ask that the facility accept the competent adult on his own signature. Explain that the agency has been advised not to co-sign admission agreements, and that the facility has potential liability in acting on the basis of decisions by a party which co-signs agreements without legal authority to do so.

(2) If the facility staff are concerned about financial responsibility for the client's expenses, and if the adult is eligible for Medicaid or State/County Special Assistance for Adults (whichever is appropriate), confirm that the agency will assume financial responsibility to the extent that Medicaid or Special Assistance will cover the cost of care. If the adult is ineligible, discuss with the facility the arrangements that have been made for payment.

(3) If the facility staff is concerned about the availability of someone to assume responsibility for decisions about the adult's care in the event that he becomes incapable of making such decisions:

> (a) Assist the adult in establishing a Durable Power of Attorney or Health Care Power of Attorney which would go into effect if the adult becomes incompetent. If the adult has no responsible party who is willing or able to serve as an attorney-in-fact or health care agent, the agency might consider being designated to act in this capacity, being authorized to make decisions about care and treatment on his behalf; or

(b) Confirm (in writing if necessary) that the agency will be available to assist with protective services and/or a guardianship proceeding if appropriate.

X. Post-Placement Adjustment

A. State Policies

County departments of social services are responsible for providing or facilitating services to assist clients receiving Adult Placement Services to adjust to their placement or independent settings. This includes clients for whom the county department has facilitated placement arrangements as well as clients already living in facilities that request or are referred for services.

Adjustment services include psychosocial adjustment as well as assuring that supportive services and financial arrangements are in place.

These services may be facilitated by assuring that another agency, facility staff member, family member or other representative is assisting the client with adjustment. If another agency, facility staff member, family member or representative is not assisting the client, the social worker will provide these services until a satisfactory adjustment has been made or until alternate services are in place for the client. The county department must provide or facilitate adjustment services a minimum of thirty days after the client's admission or relocation to a facility or other living arrangement.

B. Social Work Practice Guidelines

All clients who move to substitute living arrangements, including a move from a facility back to an independent setting, undergo a transitional period when adjustment is being made to the new setting. Clients who have been involved in the decision-making and planning process and who have been prepared for what to expect may make a rapid adjustment. Other clients may have more difficulty in adjusting and need more intense or longer assistance. Still others may need services on a long-term basis to help them maintain an adequate adjustment and prevent disruption of a placement.

1. Components of Adjustment Services

Services which may be needed are varied, including counseling, advocacy, dispute resolution, and arranging for resources or supportive services. These components also include helping the family and other significant persons to remain appropriately and actively involved in the client's life.

a. Counseling

Counseling may be needed to help the client work through the grieving process related to change and losses associated with a placement and to establish a maximum level of emotional and physical independence within a placement setting. The client may need help in framing placement as a positive change and in making linkages from the past to the present. He also will need to enhance his coping skills or learn new ones to get his needs met within the setting.

The social worker should be alert for cues of depression, agitation disorientation, or inappropriate behaviors exhibited in an attempt to adjust. If there is a pattern of any of these behaviors prior to placement or if the client has been involved in a series of disrupted placement arrangements, it is especially important to be alert for them and to have facility staff be alert for them after placement. Counseling may be needed to help the client understand how his own behaviors contribute to placement disruption, and how he can change those behaviors. The family may also need counseling to deal with changes in their lives as a result of a client's placement, and to cope with associated feelings of guilt and loss. If some family members disagree with this decision, they may need help in coming to terms with the decision for placement so they do not hamper the client's adjustment. One symptom a family member may show which might indicate unresolved feelings about a client's placement may be a series of complaints about the placement setting which are unfounded or which a client does not have. These situations need to be looked at closely to assure that the client's needs are, in fact, being met and that the client is satisfied. If this is so, the social worker needs to determine whether a counseling intervention is needed with the family member.

If the client has returned from a facility to an independent living arrangement, counseling may be needed to help the client establish routines and activities and get personal needs met without the structure of a facility. The family may also need help in re-establishing or establishing appropriate care giving responsibilities while

allowing for the client's independence. They may need to deal with anger or other feelings related to the restriction that care giving places on their own lives and determine how to prevent or relieve caregiver stress.

b. Advocacy
The social worker may need to advocate on behalf of the client when the client and his family cannot do so. Advocacy may be needed with facility staff when the client's needs are not being met or his rights are being violated, or with other service providers to obtain resources and services which would be of benefit to the client or family. Advocacy might be particularly important when the client is being discharged from a facility, in order to stop the discharge process or delay the discharge until other plans can be made. Sometimes, the social worker will need to enlist others to assist in advocacy, such as the community advisory committee, regulatory agencies, or ombudsman. Ultimately, the social worker should attempt to help the client and family become empowered and learn to advocate for themselves.

c. Dispute Resolution
Sometimes the client's adjustment is hampered by disagreements with facility staff members, with other residents in the facility, or with family members. Tension and misunderstandings can occur when a client who is accustomed to living independently is requested to cope with restrictions, lifestyles and behaviors different from his own in a placement setting. If in an independent setting, he may have disputes with caregivers or service providers about the amounts or types of care being provided. The disputes may involve the client's attempts to regain more control over his life and/or others' attempts to control the situation. Sometimes the social worker can negotiate settlements in disputes, helping the parties to see the other points of view and reframe their positions to achieve resolution. Another option is for the social worker to involve a long term care ombudsman if the client is residing in a facility. Again, ultimately the goal is for the client or family to be able to settle these differences, so in dispute resolution, the social worker should educate the client and/or family and model behaviors conducive to dispute resolution.

d. Arranging for Resources
Sometimes, even with appropriate planning and preparation, the placement or independent living arrangement does not totally meet the client's needs. The client may have an illness or impairment, or may exhibit behaviors which would be better managed in another setting if available. When services which are needed by the client are lacking, it may be necessary for the social worker to help the client obtain them. Health care or in-home aide services, supplies, day placements activities, mental health treatment or other personal needs may need to be arranged through the DSS or other community agencies, such as health departments' area mental health programs developmental day programs, etc. Some needs may not be met with the personal funds of the client, in which case the social worker may need to search for resources from the facility, agency, family, or other community organizations. Some clients may also need guardians, attorneys-in-fact appointed in Powers of Attorney, health care agents, or representative payees to assist with their ongoing decision-making or financial arrangements.
Most of these needs should have been identified prior to the placement or move to an independent setting and arranged to be met. However, sometimes this is an ongoing process, particularly if the relocation was done quickly.

2. When Adjustment Services Are Provided by another Agency or Person
If another person or agency is involved in helping the client to adjust, the social worker may only need to be minimally involved in the transition period. This person may be staff of a facility, such as a social worker in a nursing home, or a family member or other significant person who is involved with the client. It may also be staff of another county department of social services, if a placement or other living arrangement has been made out of the county and that county department has agreed to provide the services. In these situations, the social worker will want to keep in contact with this person or persons to assure that services are being given and the adjustment process is going smoothly.
Depending on the relationship the social worker has developed with the client, the social worker may still need to remain involved with the client for continuity of care and to work toward case termination. The social worker

should also be prepared to more directly intervene when problems arise or it appears that adequate services are not being provided.

3. Adjustment Services for Clients Returning to an Independent Setting
When a client is placed in a temporary arrangement (for rehabilitation, respite care, when a client requests assistance in leaving a facility, or during an interim when other housing and services are unavailable, etc.), adjustment services should be viewed broadly to include not only the placement but also the services which will be needed when the client leaves the placement. In other words, if the client will be returning home or to another community setting, the client and family will need to be emotionally and physically prepared for it. If the client will be going to another facility, he will need preparation just as one does with an initial placement to make a change in routines and grieve the change and learn how to cope.
Sometimes a client will want to leave a facility when the social worker, physician, family members or others do not believe it is in his best interest. In this case, the social worker should determine, with the client, what will need to happen for the client to live independently. This may be for client behaviors to change, for health to improve, for housing to be obtained, for the financial situation to change, for a family situation to improve, or for services to become available. Upon determining what needs to happen, goals and activities can be set which will help the client progress toward leaving the facility. There may be transitional services, such as adult day care, which would help the client transition to more independent living. Alternately, the client may then be able to see that his long-range goal of leaving may not be possible, and counseling around adjustment issues can then take place if the client's return home or to a more independent setting is planned, the social worker may need to arrange in-home, day care, or other services to support this plan. Depending on local agency policies and procedures, the development of the discharge plan may need to be coordinated with another social worker within the agency or another service provider.

4. Distinguishing Between Adult Placement and Other Services
Sometimes placement services overlap with or are provided in conjunction with other services, such as Guardianship or the Representative Payee component of Individual and Family Adjustment (WA) Services. A guardian or representative payee may be needed for ongoing support to the client in a placement setting. Developing a service plan which includes Guardianship or Payee services is part of the responsibility in Adult Placement Services for assuring that adjustment to a placement setting is achieved and maintained. However, the requirements of establishing Guardianship through the court, planning for services after Guardianship is established, and the decision-making and documentation requirements related to Guardianship are all part of the Guardianship service; similarly, making financial arrangements after appointment are part of IFA Representative Payee services. Unless the social worker is actively continuing to work with the client around psychosocial adjustment to placement or working with the client to relocate. Adult Placement Services can usually be terminated and Guardianship or Representative Payee services provided on an ongoing basis, if psychosocial adjustment or relocation services are being provided. Adult Placement Services should continue as well as Guardianship or WA-Representative Payee, whichever is appropriate.

XI. Termination of Adult Placement Services

A. State Policies

Prior to Adult Placement Services being terminated, the social worker must review available information and make contacts with significant persons to determine whether services are needed to be continued, and to reach closure with the client and involved parties. If there are no identifiable client needs that can be addressed by the agency, or those needs are being met by another party, Adult Placement Services may be terminated in accordance with policies in the Family Services Manual, Volume VI, Chapter II, and Section 8070. If Adult Placement Services have been ordered by the court under Adult Protective Services, services will terminate when the order expires.

Contacts may be made in person, by telephone, or by letter but must be made in a manner that allows for sufficient information to be obtained to make a determination about the need for services.

Documentation must reflect the contacts which were made to make the determination.

B. Social Work Practice Guidelines

1. Routine Termination of Adult Placement Services

Termination of Adult Placement Services should be done in a planned way in order to meet two purposes. First, a determination should be made regarding the need for continued services. Second, the client and family should have an opportunity to reach closure with the social worker.

In reviewing available information and in making contacts prior to termination, the social worker, client and others should determine if the client's problems and goals reflected in the service plan have been met. The contacts should be meaningful, revealing how the client is functioning in the physical, mental, social, ADL/IADL, economic, and environmental realms, and an overall picture of the progress which has been made if the client and family have adjusted, or the adjustment process has begun and someone else is facilitating the process, the client is probably no longer in need of the service.

If the social worker and client or family has developed a relationship which is significant, the termination process should include attention to emotional content. Ideally the client and family will have been informed from the beginning that involvement with the social worker will be time-limited, and that when goals are met, the involvement will end. If this has happened, everyone will have been preparing for this outcome and it will not be a surprise. If this is not the case, the social worker may need to make several contacts with the client or family for closure. During these contacts, a review can be done of what has happened, how goals have (or have not) been met, and how the client and/or family is now better able to meet their own needs.

If there are new problems or goals, it should be decided whether the client or others can work toward meeting them or whether the social worker needs to remain involved. This should involve a decision about whether the client continues to meet the target population for the service. This will help determine whether it is feasible for the client to continue receiving services.

2. Termination When the Client Does Not Benefit from Adult Placement Services

There are some clients who are not able to benefit from Adult Placement Services because they are not able to develop or carry out activities in a viable service plan. Sometimes, a client at intake and assessment appears to meet one of the target populations, but during work and ongoing assessment with the client, it becomes apparent that he does not. Sometimes, there are factors which would indicate that another agency is a more appropriate service provider, or the client, for whatever reasons, is not able to cooperate in the delivery of the service. If the service plan does not seem to be working, the social worker should assess the reasons with the client and perhaps try some alternate strategies. There are a number of different strategies which should be considered:

a. reassesses the goals with the client, and makes a determination about whether the current service plan enables the client to achieve those goals;

b. review the service plan with the client, modifying it as needed and contracting with him about what he is willing and able to do to implement the plan;

c. more thoroughly assess the client's family system (interpreting "family system' broadly) to determine if there are factors which are contributing to the failure of the service plan, and enlist assistance and support from this system;

d. conduct a multi-disciplinary/multi-agency staffing to get other ideas and to assure that involved parties or agencies are not inadvertently confusing the goals and service plan;

e. obtain a physical or mental examination from a physician or mental health professional to determine if the client has physical or mental illnesses or drug reactions which are having an effect on his ability to follow through with the service plan;

f. work with facility staff, mental health professionals or others to manipulate the environment or set up a behavior management program or different form of counseling for the client:

g. refers the client to another unit within the agency or another service provider, if indicated.

All of the techniques that are tried should be documented thoroughly.

The social worker needs to be thorough and careful in a determination to terminate services when the client does not seem to be benefiting from services. A decision should be made about whether there is a basis for termination according to the Family Services Manual, Volume VI, Chapter II, and Section 8070. The social worker should get the support of his supervisor to terminate the case when all appropriate strategies have been tried, and be able to document and explain the reasons for termination.

XII. Coordination with Other Service Providers

A. State Policies

Documentation in the client's case record must include information about other agencies or service providers who are known to be involved with the client. If any of those parties are involved in placement, adjustment, or relocation services with the client, documentation must reflect how these services are being coordinated so as not to duplicate efforts. If the placement social worker in the department of social services is the most appropriate or only source of assistance, and the client meets the criteria in the target population in IV, A.2., an application must be made in accordance with policies in the Family Services Manual, Volume VI, Chapter II, Section 8065, and Adult Placement Services provided.

B. Social Work Practice Guidelines

When Adult Placement Services are requested, the screening should include information about other involved parties delivering services and, if there are other involved parties the reason the social worker in the county department of social services is the most appropriate source for service delivery. In a domiciliary or nursing home, it should be determined whether licensure or Bill of Rights issues are the primary problem, in which case, the Adult Homes Specialist, staff of the Division of Facility Services, or long-term care ombudsman may be a more appropriate source of assistance. In continuing retirement centers or multi-unit housing, there may be a case manager or housing manager who can arrange for resources. Clients who are involved with area mental health programs may have case managers or social workers in that service system that can provide the services. Licensure rules require nursing homes to provide social work services, and each patient's plan of care is to contain a plan for meeting his social needs. Generally, social workers in nursing homes should be able to provide most social work services that the department of social services can provide, including adjustment services, referrals for other resources, financial services, and discharge or transfer. However, those rules also allow for referrals to the department of social services to be made. Similarly, hospital discharge planners normally provide placement services as part of their discharge planning, but licensure and accreditation rules are not specific about how those services should be provided.

Depending on the nature of the problem, and time and resources available, it may be appropriate for the DSS placement social worker to offer consultation to the involved social worker or case manager in another setting who will then provide the direct services. In these situations, a case should not be opened for services. However, there may also be circumstances in which the placement social worker from the county DSS is the most appropriate source of direct assistance to the client. Examples of this might be when the person is already a client of the DSS, the DSS has access to information and/or relatives of the client, the DSS social worker has greater access to the needed resources, or the DSS social worker has greater skills or expertise in a particular area than does the other involved party. These situations can be explored on a case-by-case basis. The social worker should determine what services have already been offered or provided by the other involved social worker, case manager or other professional and why the DSS is the most appropriate service provider before becoming directly involved, while being careful to be sure individuals who need assistance are served. Services should not be duplicative.

Another option is to develop formal or informal memoranda with local service providers and agencies who might be involved in the delivery of placement services. The memoranda would reflect a shared understanding of the circumstances under which each agency would become involved in placement services to clients, and how communication and coordination would take place. These memoranda would help to prevent misunderstanding and duplication of efforts among local agencies.

The DSS is also sometimes represented on interagency teams, where cases are staffed and agencies determine who will take various responsibilities in serving the clients. This is sometimes an efficient way to plan services and service provision and to avoid duplication of efforts by agencies.

XIII. Coordination with Other County Departments of Social Services

A. State Policies

No applicable Adult Placement Service policy.

B. Social Work Practice Guidelines

Under the provisions of North Carolina General Statute 153A-257, legal residence in a county determines which county is responsible for providing public assistance for eligible persons as well as other social services. Generally, a person has legal residence in the county in which he resides. However, a person who is in a hospital mental institution, nursing home, boarding home, confinement facility or similar institution or facility does not, solely because of that fact, have legal residence in the county in which the institution or facility is located. It is usually presumed that a person in a facility or institution retains legal residence in the county where he lived in a private living arrangement prior to entering a facility.

Consistent with this legal framework, and with guidance found in the Family Services Manual, Volume VI, Chapter II, Section 8060, the county of legal residence is responsible for providing Adult Placement Services for adults who are residing in facilities and institutions and who need services to help relocate or adjust to their placements. This also includes services to enable these adults to return to more independent living arrangements. Services may be provided directly to these adults by the county of legal residence, or may be provided by the county where the adult resides upon agreement by both counties. If the county where the adult resides provides services at the request of the county of legal residence, either the county of legal residence can maintain case responsibility or close the case, whereby the county where the adult resides would open the case and assume responsibility. Again, this would be decided by mutual agreement of the counties. Should the county where the adult resides assume case responsibility, it is important for information to continue to be coordinated with the appropriate income maintenance staff in the county of legal residence, since the county of legal residence will maintain responsibility for any form of public assistance the adult receives.

In order to determine which county will provide services, the following questions may be helpful:

-Which county can provide the most efficient and effective services to the client?

-Coordination with Other County Departments of Social Services 3-1-94

-Which county, if either, has greater access to the client’s family or significant others?

-Does one of the counties have greater access to resources or placement arrangements the client needs?

-What is the client’s and family’s preference regarding who will provide services?

If the county where the adult resides does not agree to provide services, it will be necessary for the county of legal residence to provide services directly to the client.

The county of legal residence may work directly with a client or facility staff in another county without contacting that county DSS. However, it would be courteous for the social worker to advise the county DSS where a placement is being made, if there is potential for the client to have adjustment problems which that county may need to address.

FL-2 (86)
INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

Appendix A

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME FIRST MIDDLE	2. BIRTHDATE (M / D / Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)

5. COUNTY AND MEDICAID NUMBER	6. FACILITY ADDRESS	7. PROVIDER NUMBER

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
___ HOME ___ DOMICILIARY (REST HOME)	___ HOME ___ DOMICILIARY (REST HOME)		___ SNF ___ HOME
___ SNF	___ SNF		___ ICF
___ ICF ___ OTHER	___ ICF ___ OTHER	13. DATE APPROVED / DENIED	___ DOMICILIARY (REST HOME)
___ HOSPITAL _____	_____		___ OTHER _____

15. ADMITTING DIAGNOSES - PRIMARY. SECONDARY, DATES OF ONSET

1.	5.
2.	6.
3.	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
☐ CONSTANTLY	☐ AMBULATORY	☐ CONTINENT	☐ CONTINENT
☐ INTERMITTENTLY	☐ SEMI-AMBULATORY	☐ INCONTINENT	☐ INCONTINENT
INAPPROPRIATE BEHAVIOR	☐ NON-AMBULATORY	☐ INDWELLING CATHETER	☐ COLOSTOMY
☐ WANDERER	**FUNCTIONAL LIMITATIONS**	☐ EXTERNAL CATHETER	**RESPIRATION**
☐ VERBALLY ABUSIVE	☐ SIGHT	**COMMUNICATION OF NEEDS**	☐ NORMAL
☐ INJURIOUS TO SELF	☐ HEARING	☐ VERBALLY	☐ TRACHEOSTOMY
☐ INJURIOUS TO OTHERS	☐ SPEECH	☐ NON-VERBALLY	☐ OTHER:
☐ INJURIOUS TO PROPERTY	☐ CONTRACTURES	☐ DOES NOT COMMUNICATE	☐ O2 PRN CONT.
☐ OTHER:	**ACTIVITIES/SOCIAL**	**SKIN**	**NUTRITION STATUS**
PERSONAL CARE ASSISTANCE	☐ PASSIVE	☐ NORMAL	☐ DIET
☐ BATHING	☐ ACTIVE	☐ OTHER:	☐ SUPPLEMENTAL
☐ FEEDING	☐ GROUP PARTICIPATION	☐ DECUBITI-DESCRIBE:	☐ SPOON
☐ DRESSING	☐ RE-SOCIALIZATION		☐ PARENTERAL
☐ TOTAL CARE	☐ FAMILY SUPPORTIVE		☐ NASOGASTRIC
PHYSICIAN VISITS	**NEUROLOGICAL**		☐ GASTROSTOMY
☐ 30 DAYS	☐ CONVULSIONS/SEIZURES		☐ INTAKE AND OUTPUT
☐ 60 DAYS	☐ GRAND MAL	☐ DRESSINGS:	☐ FORCE FLUIDS
☐ OVER 180 DAYS	☐ PETIT MAL		☐ WEIGHT
	☐ FREQUENCY		☐ HEIGHT

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
☐ BLOOD PRESSURE		☐ BOWEL AND BLADDER PROGRAM	
☐ DIABETIC URINE TESTING		☐ RESTORATIVE FEEDING PROGRAM	
☐ PT (BY LICENSED PT)		☐ SPEECH THERAPY	
☐ RANGE OF MOTION EXERCISES		☐ RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION

21. PHYSICIAN'S SIGNATURE 22. DATE

372-124 (4-87)

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NORTH CAROLINA MEDICAID PROGRAM
Instructions for Completion of FL-2

To be used for Prior Approval, Utilization/Continued Care Review and Onsite Medical Review. Check (√) the appropriate block to indicate the type of review. Complete or check (√) ONLY those blocks appropriate to the patient at the time the form is completed.

Identification

1. **Patient Name:** Print last name first, first name, middle initial. If no middle name indicate nmn.
2. **Birthdate:** Enter month, day and year.
3. **Sex:** Enter capital F to indicate female or M to indicate male.
4. **Admission Date:** (current location): Enter month, day, year.
5. **County and Medicaid Number:** Enter 2 digit county number and 9 digit and alpha suffix medicaid number.
6. **Facility Name and Address:** Enter complete name of facility and street address.
7. **Provider Number:** Enter 7 digit number for current level of care.
8. **Attending Physician and Address:** Enter complete name and address.
9. **Relative Name and Address:** Enter complete name and address.
10. **Current Level of Care:** Indicate current level of care provided by check (√) appropriate block.
11. **Recommend Level of Care:** Check (√) the correct level of care that is recommended.
12. **Prior Approval Number:** Enter 9 digit number for current level of care.
13. **Date Approved/Denied:** Leave blank for internal processing.
14. **Discharge Plan:** Indicate with a check (√) that which is appropriate. This information may be found in the written Discharge Plan retained in the patient's record.

Medical Components

This must be completed by professional medical personnel (physician, nurse or health personnel) and should be as complete as possible to allow for accurate determination of patient needs.

15. **Diagnoses:** Enter primary, secondary, etc. with dates of onset or surgery.
16. **Patient Information:** Check only (√) those blocks applicable to this patient under the designated heading. It may be necessary to check (√) more than one block under a heading or write additional information in blanks.
17. **Special Care Factors:** Indicate in writing the frequency of those applicable.
18. **Medications:** List present medications, dosage and route of administration.
19. **X-ray/Laboratory Findings/Date:** Include if available.
20. **Additional Information:** Use to provide any additional data or information pertinent to the care of the patient and that which justifies the type of care requested.
21. **Physician's Signature:** The physician must validate by signature the care needs presented on this patient.
22. **Date:** The FL-2 must be dated by the physician who signs the form.

Definitions

SNF requires 24 hours nursing care according to a plan of care by a physician with a licensed nurse on duty at all times.

ICF requires at least 8 hours nursing care per day by a licensed nurse with the remaining time and services provided by experienced staff under the direction of a licensed nurse according to a plan of care by a physician.

Rest Home - requires residential care; 24-hour supervision; personal care; and administration of medications as directed by a physician.

Home Health services may be provided in a **rest home** or a **patient's home** when prescribed by a physician.

Community Alternatives Program provides an alternative to institutional placement through community living if non-institutional community services are feasible and preferred by client.

Ambulation Levels

Ambulatory - patient is one who is fully mobile and does not need the continuing help of a staff member, wheel chair, etc. to move about.

Semi-Ambulatory - patient is one who needs and uses the assistance of a wheel chair or walker or crutches or other appliances or a staff member on a regular and continuing basis to move about.

Non-Ambulatory - Patient is one who is bedfast. However, a bedfast resident with the assistance of a facility staff member may use the bathroom or be able to sit up occasionally, e.g. in a chair 1-2 hours at a time during the day.

Mailing Instructions

Utilization/Continued Care Reviews
Division of Medical Assistance
Attn: Utilization Control Section
1985 Umstead Drive
Raleigh, North Carolina 27603
Telephone 919/733-6257

Prior Approval
EDS-Federal Corporation
Attn: Prior Approval
Post Office Box 31188
Raleigh, NC 27622
Telephone 1-800-662-7049

INSTRUCTIONS ON BACK

NORTH CAROLINA MEDICAID PROGRAM
MENTAL RETARDATION SERVICES

Appendix B

☐ PRIOR - APPROVAL ☐ ON-SITE ☐ UTILIZATION REVIEW

PATIENT - INFORMATION - PA.

PATIENT NAME (LAST, FIRST, MIDDLE)			7. FACILITY		8. PROVIDER NUMBER
2. BIRTH DATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)	9. TYPE OF FACILITY	10. CURRENT LEVEL	11. REC. LEVEL OF CARE
5. COUNTY	MEDICAID NUMBER		12. PRIOR APPROVAL NUMBER		13. DATE APPROVED/DENIED
6. RELATIVE			14. ATTENDING PHYSICIAN		

DIAGNOSIS

15. MENTAL RETARDATION

COGNITIVE LEVEL
- _____ MILD
- _____ MODERATE
- _____ SEVERE
- _____ PROFOUND

ADAPTIVE LEVEL
- _____ MILD
- _____ MODERATE
- _____ SEVERE
- _____ PROFOUND

16. CAUSE OF MENTAL RETARDATION _____

17. CURRENT MEDICAL DIAGNOSIS _____

18. HEIGHT _____ WEIGHT _____ BP _____ | 19. BOWELS: ____ CONT. ____ INCONT. _____ | 20. URINARY: _____ CONT. ____ INCONT. ____ CATHETER

PATIENT EVALUATION

21. MEDICAL CONCERNS
- _____ OSTOMY CARE
- _____ ESOPHALGEAL REFLUX
- _____ HX OF DECUBITUS ULCER
- _____ CONTRACTURES
- _____ DIABETIC
- _____ HYPERTENSION
- _____ INSOMNIA
- _____ OTHER _____

22. FUNCTIONAL LIMITATIONS

VISION
- _____ NORMAL
- _____ IMPAIRED
- _____ BLIND

HEARING
- _____ NORMAL
- _____ DEAF
- _____ OTHER

SPEECH
- _____ NORMAL
- _____ NON-COMMUNICATIVE
- _____ GESTURES
- _____ ECHOLALIC

23. NUTRITION
DIET: _____
- _____ FEEDS INDEPENDENTLY
- _____ W/ASSISTANCE
- _____ PARENTERAL
- _____ TUBE

24. SKIN
- _____ NORMAL
- _____ OTHER _____

25. PERSONAL CARE

BATHING
- _____ INDEPENDENT
- _____ W/ASSIST.
- _____ TOTAL ASSIST.

DRESSING
- _____ INDEPENDENT
- _____ W/ASSIST.
- _____ TOTAL ASSIST.

26. AMBULATION
- _____ INDEPENDENT
- _____ AMB: W/ASSISTANCE
- _____ NON AMB/MOBILE
- _____ NON-AMB/NON MOBIL

27. BEHAVIORAL PROBLEM
- _____ VERBAL ABUSE
- _____ COMBATIVE
- _____ INAPPROPRIATE BEHAV.
- _____ WANDERER
- _____ RUN AWAY

INJURIOUS
- _____ PROPERTY
- _____ SELF
- _____ OTHERS

28. BEHAVIORAL CONTROL
- _____ BEHAVIORAL PLAN
  - ___ MODERATE/MILD
  - ___ SEVERE/PROFOUND
- _____ PSYCHOTROPIC MEDS
- _____ PHYSICAL RESTRAINTS
- _____ TIME OUT

29. SUPPORTIVE/PROTECTIVE DEVICES
- _____ NONE
- _____ WHEELCHAIR
- _____ WALKER/CRUTCHES/BRACES
- _____ HEARING AID
- _____ GLASSES
- _____ ADAPTIVE CLOTHING
- _____ ADAPT EATING UTENSILS
- _____ HELMET
- _____ SUPPORTIVE BELTS
- _____ BEDRAILS
- _____ LAP TRAYS
- _____ MODIFIED SHOES
- _____ MITTENS/SPLINTS
- _____ OTHER _____

PLAN OF TREATMENT

30. CURRENT NEEDS
- ____ NURSING
- RESTRAINTS _____
- TYPE _____
- SEIZURE CONTROL ____
- ____ PHYSICAL THERAPY
- ____ OCCUPATIONAL THERAPY
- ____ SPEECH THERAPY

31. LENGTH OF CARE
DISCHARGE PLAN
- _____ OVER 180 DAYS
- _____ 60-180 DAYS
- _____ 30-60
- _____ OTHER _____

32. PHYSICIAN VISITS
- ___ 90 DAYS
- ___ OTHER _____

33. MEDICATIONS: DOSAGE, ROUTE, FREQUENCY.

34. HABILITATION PLAN GOALS/OBJECTIVES/ACTIVITIES _____

35. DIAGNOSTIC PROCEDURES _____

36. REHABILITATION POTENTIAL

37. REASON FOR LEVEL OF CARE/OTHER COMMENTS:

38. M.D. SIGNATURE _____ 39. DATE _____

1-123

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Instructions for Completion of MR-2

To be used for prior approval, utilization/continued care review and on-site medical review. Complete or check(√) ONLY those blocks appropriate to the patient at the time the form is completed. Check (√) the appropriate block to indicate the type of review.

INFORMATION

Identification

1. **Patient Name:** Print last name, first name, middle initial. If no middle name, indicate NMN.
2. **Birthdate:** Enter month, day and year.
3. **Sex:** Enter Capital F to indicate female or M to indicate male.
4. **Admission Date:** (current location): Enter month, day and year.
5. **County and Medicaid Number:** Enter 2 digit county number and 9 digit and alpha suffix Medicaid number.
6. **Relative Name and Address:** Enter complete name and address.
7. **Facility Name and Address:** Enter complete name of facility and street address.
8. **Provider Number:** Enter 7 digit number for current level of care.
9. **Type of facility:** Enter ICF/MR, ICF, SNF or hospital, etc.
10. **Current Level of Care:** Enter current level of care provided.
11. **Recommended Level of Care:** Enter the level of care that is recommended.
12. **Prior Approval Number:** Enter 9 digit number for current level of care. Leave blank when requesting Prior Approval.
13. **Date Approved/Denied:** Leave blank for internal processing.
14. **Attending Physician and Address:** Enter complete name and address.

DIAGNOSIS

15. **Mental Retardation Level:** Check (√) the degree of cognitive and adaptive retardation.
16. **Cause of Mental Retardation:** Enter the cause of retardation.
17. **Current Medical Diagnosis:** Enter medical diagnoses that are pertinent currently.

PATIENT EVALUATION

18. **Height:** Enter height or length (infants), if available; weight, blood pressure.
19. **Bowels:** Check (√) continent or incontinent.
20. **Urinary:** Check (√) continent, incontinent or catheter.

21. - 33. **Check** (√) or complete those blocks appropriate to patient at this time.

PLAN OF TREATMENT

34. **Habilitation Plan:** Enter briefly the programs planned and/or implemented with goals / objectives.
35. **Diagnostic Procedures:** Enter procedure, date and results (for Utilization Review, enter procedures since last UR).

36. and 37. **Enter reason(s)** the patient requires placement at the recommend level of care: rehabilitation potential, and other pertinent comments about the patient's condition not indicated above.

38. **Physician's Signature:** The Physician must validate by signature the care needs presented on this patient.
39. **Date:** The MR-2 must be dated by the physician who signs the form.

MAILING INSTRUCTIONS

Utilization/Continued Care Reviews
Division of Medical Assistance
Attn: Utilization Control Section
1985 Umstead Drive
Raleigh, North Carolina 27603

Prior Approval
EDS Federal Corporation
Attn: Prior Approval
Post Office Box 31188
Raleigh, NC 27622

NORTH CAROLINA PRE-ADMISSION AND ANNUAL SCRRENING REQUIREMENTS FOR NURSING FACILITIES

PASARR, *Preadmission Screening and Annual Resident Reviews*, is a federally mandated program for screening applicants and residents of Medicaid certified nursing facilities that are suspected as having mental illness (MI), mental retardation (MR), and/or conditions related to mental retardation (RC). PASARR screenings must be performed prior to admission and annually thereafter for persons who are suspected as meeting the federal definitions for MI, MR. and/or RC. A Level I screening must be performed before anyone, regardless of pay source, can be admitted to any Medicaid certified nursing facility. When the level I screening indicates the possibility of MI, MA, or RC, a Level II must be performed to assess the placement and care needs of the individual. For those people who have had a Level II screen and are in nursing facilities, an annual resident review is required each year.

The following procedures will address PASARR (Level I and Level II) screens and their processes, as well as the State's plans for assuring that PASARR screens have been performed for all appropriate current nursing facility (NF) residents of Medicaid certified facilities. Section I reviews the PASARR processes for both Level I and Level II screens, while Section II will overview the *Quality Review* process for screening current mentally ill and mentally retarded nursing facility residents of Medicaid certified facilities who are not presently enrolled in the PASARR program. Section III provides instructions for the Level I protocol and Section IV supplies general definitions and other administrative information regarding PASARR.

First Mental Health, Inc (FMH) has been selected by the Department of Human Resources to conduct and coordinate the aforementioned screening processes, to include: ***Level I Screens*** (which apply to all applicants and residents of Medicaid certified NFs); ***Level II*** Screens (which apply to all NF applicants and residents with suspected mental illness and/or mental retardation), and; the ***Quality Review Process*** (which will be a collaborative effort between all Medicaid certified NFs and FMH to identify residents who should be enrolled in the PASARR process).

These procedures are effective 2/1/94. FMH can be contacted with the protocol data for preadmission and change in status Level I screens by telephone, fax, or mail, as follows:

First Mental Health, Inc.
501 Great Circle Road; Suite 300
Nashville, TN 37228
(Attn: NC PASARR)
Phone: (800) 598-6462
Fax: (615) 256-0786

The referral source (hospital discharge planner, NF staff, county case worker) is responsible for contacting FMH before **any applicant**, regardless of payment status, is admitted to a North Carolina Medicaid certified NF. FMH reviewers will utilize the protocol found on page 22 (Section III of this manual) to arrive at Level I determinations and the referral source should be prepared to provide the protocol information. The reviewer will ask specific questions regarding the individual's history, behaviors and diagnoses, medical and pharmacological treatment. If the referral source is able to provide the complete protocol information, the telephone component of these screens should be expedited promptly. If information is submitted by fax/mail, a determination should be available within **24** hours of receipt of information by FMH.

For persons who are Medicaid applicants or recipients, the Level I and Level II (if applicable) screens must be performed prior to contact with the Division of Medical Assistance's fiscal agent, Electronic Data Systems (EDS) for level of care determination. Following completion of the appropriate screen(s), FMH will assign an

authorization number. This number should be communicated to EDS at the time of level of care review to obtain a prior approval number. This prior approval number will continue to be the Medicaid billing number.

The FMH Level I authorization number will usually be assigned the day of screening and will be communicated to the referral source when the screen is complete. For Level II individuals (persons suspected as meeting criteria for mental illness/mental retardation), the authorization number will be assigned when the Level Il is completed (usually within 7 days from referral for a Level II evaluation). FMH will phone the referral source to communicate both the screening results and the authorization number at the conclusion of the Level II.

To conduct a telephone review, call 1-800-598-6462 between 8:00 a.m. and 5:00 p.m. and request a North Carolina PASARR review. For general information on procedures and review status, ask for the NC PASARR administrative assistant. For problem resolution or policy clarification, ask for the NC PASARR program manager.

TABLE OF CONTENTS

SECTION 1
PASARR

I.A PASARR (LEVEL I AND LEVEL II) OVERVIEW

The following procedures were developed in response to the requirements of the Federal *Nursing Home Reform Act of 1987* (Subtitle C of Public Law 100-203, OBRA '87). This act requires States participating in the Federal Medicaid program to establish special preadmission and annual screening processes for applicants and residents of Medicaid certified nursing facilities with serious mental illness (MI), mental retardation (MR), and conditions related to mental retardation (RC).

The PASARR (*Preadmission Screening and Annual Resident Review*) program developed out of the discovery that Federal deinstitutionalization requirements resulted in large numbers of "trans-institutionalized" mentally disabled persons from state hospitals to nursing facilities (NFs). For many of these people it was discovered that, in addition to not requiring nursing facility services, they were not receiving needed treatment for their mental disabilities.

PASARR is an advocacy program designed to respond to those issues, with the responsibility of insuring that persons with mental disabilities are placed in the least restrictive living environments, maximizing their functional capacities, and that the placements meet any special treatment needs the individuals may have. Its evaluation process, referred to as *a Level II*, accomplishes this task through the performance of a thorough evaluation which ultimately determines (both prior to admission and annually thereafter) a response to each of the three federally mandated questions:

1. Whether the NF applicant/resident does, indeed, have a disability of Ml and/or MR/RC and, if so;
2. Whether the NF applicant/resident requires the level of services provided by a nursing facility and;
3. Whether the individual requires specialized services for his/her mental disability.

In order to identify persons who fall within the purview of PASARR**,** States are required to design a screening system for all applicants to Medicaid certified nursing facilities, regardless of payment source. Swing-bed placements are currently exempt from this process. Referred to as the Level I or "*identification screen*," this initial process asks specific diagnostic and functional questions about applicants and residents to identify those persons with mental illness, mental retardation, and conditions related to mental retardation. The Level I and, when required, the Level II screens must be performed prior to nursing facility admission (excluding those situations discussed in subsection I.E; pages 6-7). Individuals determined to meet the Ml and/or MR/RC definitions must then be evaluated annually if admitted to Medicaid certified nursing facilities.

1.B LEVEL I SCREENS

Level I screens apply only to Medicaid certified nursing facility applicants/residents (swing-beds are exempt) and occur:

1) Prior to nursing facility admission;
2) Whenever there is a significant change in status in a nursing facility resident (referred to as a "status change"; see pages 6-7).

Level I screens do not apply to the following individuals:

1) Individuals who have had a previous Level I and who are re-admitted to a nursing facility after treatment in a hospital (unless there has been a significant change in status for an individual with MI or MR/RC (see page 61. Such cases would be referred to FMH following readmission).
2) Individuals who have had a previous Level I and who transfer from one facility to another.
3) Individuals admitted to swing beds.

Other than the exceptions noted above, all applicants for admission to Medicaid certified nursing facilities must have a Level I screen to determine the potential presence of "serious mental illness," mental retardation, (or a related condition) prior to their admission to nursing facility care. Each of these conditions is defined in Section IV, under *Definitions* (page 25).

If the referral source is initiating a Level I screen for an individual with Ml or MR/RC and the individual also has a primary diagnosis of a dementing illness (e.g., Dementia or Alzheimer's disease), the individual may not require Level II screening or may be allowed an abbreviated Level II screen. The referral source can avoid unnecessary Level II screens and the delays associated with them if they can provide clear evidence of a dementia diagnosis; e.g., a neurological assessment and diagnosis, a mental status exam establishing symptoms of disordered memory and orientation, or other information specific to establishing that the symptoms of dementia supersede the symptoms/conditions associated with mental illness or mental retardation.

If the Level I screen indicates that the applicant does have symptoms of mental illness or mental retardation, s/he will be referred for a Level II evaluation. The Level II will be performed, regardless of whether the individual is a Medicaid recipient or applicant or is a private payer, and must be completed prior to the individual's admission to a Medicaid certified nursing facility. The referral source will be notified of the possible need for a Level II screen during the initial Level I telephone call, and the process discussed on page 4 will be initiated (*"Preadmission Screen - PAS").*

I.C LEVEL I OUTCOME
As a result of the Level I screen, the following outcomes may occur:

1) **If the individual is found not to require a Level II screen and receives or is applying for Medicaid benefits** the facility should follow general procedures for Medicaid level of care screens through the North Carolina Medicaid fiscal agent, Electronic Data Systems (EDS). The referral source will be provided an authorization number which s/he will be required to supply EDS at the time of that screen. EDS will then issue a prior approval (P.A.) number based upon level of care and this P.A. number will continue to be used for Medicaid billing purposes. If the individual is approved for admission, the receiving facility must contact FMH upon the individual's admission to request a written copy of the Level I approval for the individual's records.

2) **If the individual is found not to require a Level II PA SARR screening and is not a Medicaid recipient or applicant**, the facility should follow its general admission procedures and the referral source will be provided verbal notification of this determination. The admitting facility must contact FMH upon admission to request a written copy of the Level I for the individual's record.

3) **If the individual is found to require a Level II PASARR screening**, s/he will be referred for a Level II evaluation and the referral source will be asked to forward specific information identified on page 4 of this manual (e.g., history and physical examinations, physician notes, available intellectual testing, etc.). Upon receipt of that information, the need for a Level II will be determined. If a Level II is warranted, the process will be completed within 7 business days of the Level II referral. Verbal notification of the Level II determination will be provided to the referral source by the 7th business day. During verbal notification, the facility will be provided an FMH number for the screened individual. If that individual is a Medicaid recipient or applicant, the referral source should then initiate contact with EDS for level of care determination and should provide EDS with the assigned FMH number. EDS wilt then issue a prior approval number which will be used for Medicaid

billing. The receiving facility must contact FMH upon the individual's admission to request a written copy of the Level II approval for the individual's records.

If the Level II determines that nursing facility placement is not appropriate, the referral source will be notified verbally, to be followed by written notification of the determination. The applicant/resident and/or legal guardian will also receive written notification, accompanied by notification of appeal rights through the fair hearing process.

The Division of Mental Health is the agency which will make final determinations regarding appropriateness of placement and need for specialized services and, in cases where specialized services are determined as necessary, the DMH will arrange for provision of those services. In cases where residents are determined to require transfer or discharge, the Division of Mental Health will be responsible for locating and arranging for alternative placement.

It is the responsibility of the referral source to contact the Level I screeners at FMH before an applicant is admitted to a nursing facility. Facilities are then responsible for re-initiating contact for residents meeting the criteria explained on pages 6-7.

I.D LEVEL II SCREENS

The purpose of the Level II screening is to determine if the individual has any special needs due to his/her mental condition that need to be addressed in a nursing facility or if those special needs are so significant that they cannot be met in a nursing facility and can only be met in a psychiatric hospital or a specialized facility dedicated to the care of the developmentally disabled. For those suspected of meeting criteria for Ml or MR/RC, Level II screens must be performed both prior to admission (PAS) and annually thereafter (ARR), to assess both level of care and specialized service needs.

i. Pre-admission Screens (PAS

Pre-admission screens (PAS Level IIs) must occur prior to admission (excluding those situations described on page 6; subsection I.E.) and are completed within 7 business days of referral for a Level II evaluation.

When a Level II screening is triggered by evidence or diagnosis of mental illness, mental retardation, or conditions related to mental retardation, FMH will directly coordinate a face-to-face pre-admission assessment. The referral source will be asked to send the following patient records to FMH which are required to be considered as part of a Level II screen by Federal regulations:

1. A current history and physical (performed within the past 12 months) that includes: complete medical history; review of all body systems;
2. A comprehensive drug history including, but not limited to, current or immediate past use of medications that could mask symptoms or mimic mental illness;
3. Current physician's orders and treatments.
4. Copies of most recent intellectual testing, if available (only requested for individuals with mental retardation or related conditions).
5. A copy of the FL2 or physician notes which document diagnosis (only requested for related conditions).

Receipt of this information will trigger referral for a Level II evaluation. The medical record information and the results of the face-to-face assessments will be reviewed by FMH Qualified Mental Retardation Professionals and psychiatric staff.

FMH will telephone the referral source with results of the Level II screen within seven (7) working days following receipt of the individual's records from the referring facility. **The receiving nursing facility must contact FMH to notify of the individual's date of admission, in order to receive written results of these processes (This can be accomplished by phone or by faxing/mailing the Exhibit 1 protocol [page 8])**.

Level II screens remain valid for one year unless a change in status occurs with the resident. Significant changes and other conditions which require update, as described in Section I.E (below; i-iii), should be reported to the FMH Level I screeners.

ii. Annual Resident Reviews

Annual Resident Reviews (ARR Level IIs) will be performed on all individuals identified as MI/MR by the Level I and determined through the previous Level II to meet guidelines for MI or MR/RC. As an annual review, it is federally required that subsequent evaluations occur "*annually*" following completion of the previous Level II evaluation. "*Annually*" is federally defined as occurring within the quarter of the anniversary date of the previous Level II. For example, if a previous evaluation was performed on January 12, 1993, the "*annual"* review must be performed no later than March 31, 1994. The exception to the annual evaluation is a situation where the individual's status changed to the extent that his/her mental health/mental retardation needs changed. FMH will be responsible for tracking individuals subject to these reviews and for conducting the annual evaluations.

Many of the identified residents in a particular facility will be reviewed during the same quarter. The facility will be contacted by an FMH evaluator prior to quarter in which these Level II screens are due.

The facility will be asked to have available to FMH's on-site evaluators all the medical data listed for Pre-admission Level II evaluations (previous page) and the review process will continue as described for Pre-admission screens.

These individuals will automatically be tracked by FMH and will not require any further referral to the Level I evaluators, excluding situations identified in the following sections for which information is necessary to update tracking reports and/or baseline information on the resident. This process replaces the PASARR *Update Form* (PASARR 5) so that submission of that form (next page) is no longer required of facilities.

I.E CONDITIONS WHICH MAY WARRANT UPDATED LEVEL I SCREEN (TO INCLUDE TIME LIMITED ADMISSIONS) OR UPDATES IN LEVEL II TRACKING INFORMATION

i. Status Changes

1) ***Status Chances***: A status change is evident when a change in a resident indicates the presence of newly emerging or changing mental health conditions or needs. These should be reported to the FMH Level I screener and may occur in one of three ways.

a. if a MR resident's physical status resolves significantly, such that his/her mental retardation needs are more likely to respond to treatment, the facility should report such changes to the FMH Level I screener for determination of further assessment.

b. if a mentally ill/mentally retarded individual's condition was not discovered at the preadmission screen, and that condition later emerged or was discovered, the facility should report those symptoms, diagnoses, etc. to the FMH Level I screener to determine need for further assessment. The facility should monitor data on the MDS to identify any areas which are positive for a mental disability.

c. if the previously discovered mentally ill/mentally retarded resident should exhibit increased symptoms or behavioral problems, these should be reported to the FMH Level I screener for determination of need for further assessment.

As with the Level I process, additional information may be requested to determine the need for an earlier than scheduled Level II ARR.

ii. Temporary Admissions Which Require Level I Updates
The following situations will allow for temporary time-limited nursing facility admission for MI/MR applicants meeting the specified criteria. Each of these admissions will be permitted following submission of the Level I screen by the referral source, followed by EDS authorization for Medicaid applicants and recipients. FMH will supply the referral source with an authorization number and an end-date for the time limited stay. Prior to expiration of that time period, the receiving facility must update the Level I/NF procedures if the individual's stay is expected to exceed the allotted time frame. A new authorization number will be supplied and, for Medical Assistance individuals, the referral source/facility will contact EDS to communicate the new authorization number and obtain a level of care determination.

1***) Convalescent Care*** admissions are temporarily Federally allowed without a Level II screen, as long as all of the following conditions are met: 1) Admission to a NF occurs directly from a hospital after receiving acute inpatient care, and; 2) NF services are required for the hospitalized condition, and; 3) The attending physician has certified that NF care is unlikely to exceed 30 calendar days. This physician certification must be provided to FMH at the time of the screen.

Clearly, persons whose admission for convalescence is likely to exceed 30 days (e.g., fractured hip) should not apply for this exemption. If at any time it appears that the individual's stay may exceed 30 days, and no later than the 25th calendar day, the receiving facility must perform updated Level I/NF procedures to determine whether the person continues to require NF care and to assess whether further screening (Level II) may be necessary.

2***) Provisional Admission*** allows for temporary (7 day) admission of persons whose delirium precluded the ability to make an accurate diagnosis. Facilities with admissions approved under this category must follow Level I/NF level of care procedures for an update, at such time that the delirium clears or no later than the 5th calendar day following admission. These procedures will determine need for continued care and for further assessment under the Level II process.
3) ***Emergency Admission*** Applies to: Nursing Facility Applicants who have evidence of Ml and/or MR/RC and require temporary nursing facility admission in an emergency protective services situation (NF care is approved

for no greater than 7 calendar days). If at any time it appears that the individual's stay may exceed 7 days, and no later than the 5th calendar day, the receiving facility must perform updated Level IINF procedures to determine whether the person continues to require NF care and to assess whether further screening (Level II) may be necessary. This standard applies if:

a. based on the MI/MR individual's physical and/or environmental status; there is a sudden and unexpected need for immediate NF placement;

and

b. the above need requires temporary placements until alternative services/placement can be secured no other placement options are available.

iii. Transferred/Discharged/Deceased MI/MR Residents Which Require Updates Information in this category should be reported to FMH for all residents enrolled in the PASARR process who meet criteria below:

1) ***Transfer/Discharge of MI/MR residents***: NFs should report to FMH any persons with Ml, MR, or conditions related to MR (RC) who leaves the facility. Unless there has been a significant change in status, information indicated on Exhibit 1 (page 8) is the only information that will be required. Status changes for both MI and MR residents should be reported to FMH.

2) ***Deceased MI/MR residents***: NFs should report deceased MI/MR resident information to FMH.

*Exhibit 1 (following page) provides a sample form for which in formation on transfers, discharges, admissions, and deceased residents/applicants may be communicated by fax or by mail to FMH. Facilities may also use this form to report new admissions to FMH, in order to receive copies of Level / screening results. This form rep/aces the Discharge/Transfer Notice (PASARR 5) form previously used for this purpose (a copy is included following Exhibit 1).

I.F CONDITIONS WHICH DO NOT REQUIRE AN UPDATED LEVEL I SCREEN

1) **Readmissions after hospitalization or temporary leave for persons who have had a PASARR screen** do not require a Level I or Level II screen before the readmission occurs. Under PASARR regulations, a temporary absence is defined as one in which the individual planned to return to that facility or to another facility at the end of the absence.

Although a readmission does not require a PAS (Level II) screen before admission, any significant change in status should prompt such a referral following the individual's return to the facility. For example, a MI resident treated in a psychiatric unit should receive a new resident assessment at readmission. That resident assessment should

NORTH CAROLINA NURSING FACILITIES TRACKING FORM

First Mental Health (FMH)
501 Great Circle Road; Nashville, TN 37228
Ph: (800) 598 – 6462
Fax: (615) 256 – 0786

Resident/Applicant Name_____ Date of Birth_____

Social Security Number_____ Medicaid ID#_____

Section I NEW ADMISSIONS

Complete for all NF admissions to receive screening results (Level I, Level II)
Forward to FMH for all admissions.

Admitting Facility_____ Admission Date_____

Address_____ City_____

Contact Person_____ Phone_____

Section II TRANSFERRED, DISCHARGED, DECEASED LEVEL II RESIDENTS

Complete for residents who have received previous Level II screens, in order to supply information for tracking. (Forward to FMH as such changes occur).

A. TRANSFER

Admitting Facility_____ Admission Date_____

Address_____ City_____

Contact Person_____ Phone_____

B. DISCHARGE

Discharged to: ☐ Home Discharge Date_____

☐ Basic Care

☐ Hospital

☐ Other (specify)_____

C. DECEASED

Date_____

Submitted by_____ Facility_____

Phone_____

SECTION II
QUALITY REVIEW PROCEDURES

II.A INTRODUCTION

The purpose of the *Quality Review Project* is to assure that all residents in Medicaid certified facilities have been included in the federally mandated Preadmission Screening and Annual Resident Review (PASARR) program. Applicable residents include those persons with diagnoses or indications of mental retardation, conditions related to mental retardation, and/or serious mental illness as required by P.L. 100- 203 under OBRA '87 for PASARR.

The previous section of this manual explains the required screening procedures for PASARR *(Level I and Level II screens*), while this section and Section III (*Instructions for Facilities: Level I Screening Form")* explain the requirements and procedures for Medicaid certified nursing facilities in the *Quality Review Project.*

II.B QUALITY REVIEW PROCEDURES

As a result of both terminology changes and contradictions in draft regulatory language, many states have experienced interpretation difficulties regarding criteria by which PASARR inclusion should occur. Following publication of final federal regulations for PASARR, the North Carolina Division of Medical Assistance designed a *Quality Review Project* to assure that all residents of Medicaid certified nursing facilities that should be subject to this program have been identified.

Quality Review procedures will occur as follows:

1) Facilities should complete the *Leve/ I* protocol (through Section III: Dementia Screen) for all residents who meet the guidelines specified in the following subsection ("Guidelines for Level I Protocol Completion, "page 11);

2) Following completion of the Level I for all applicable residents, the facility should contact First Mental Health, Inc. (FMH), the organization which is contracted to conduct the Quality Review Process, in order to report the names of residents identified in the process. FMH can be reached at 1-800-598-6462; ask for a North Carolina PASARR reviewer. The deadline for completion of facility Level I forms will be March 1, 1994.

3) A FMH clinician will contact the facility to schedule an on-site visit to review completed Level I screens and accompanying medical records and s/he may request interviews with the identified residents.

4) Following completion of the above, the clinician will review a sample of resident records who were not identified through *Quality Review* and who are not currently enrolled in the PASARR process. Their sample will be determined by facility size and by non-included residents who are on medications used for psychiatric conditions. Please have available facility drug records for that purpose. FMH will particularly be interested in information on residents currently being prescribed psychoactive medications.

5) The results of these reviews will be documented on the completed Level I forms. The original forms will be left at the facility and should be filed in the appropriate resident records. A copy of the forms will be returned to FMH for a final QA review. As a result of these reviews, the FMH reviewer will identify any individuals who will need further screening through the PASARR Level II process and will discuss the manner by which such screening will occur.

6) In addition to the record reviews, the FMH clinician will meet with designated facility staff (e.g., Social Worker and/or D.O.N.) to discuss the outcome of the reviews, to assure that all appropriate individuals were identified, and to further clarify procedures for "Status Change" referrals. In the event that future admissions show evidence of newly emerging or newly identified psychiatric/mental retardation conditions (or changing treatment needs for these conditions), the facility is required to report such conditions through submitting a "*Status Change*" Level I protocol to FMH. The procedures for such referrals are also outlined in the previous section of this manual.

ll.C GUIDELINES FOR LEVEL I PROTOCOL COMPLETION

The facility is responsible for completing the attached Level I (through Section III: Dementia Screen) for the following residents (if they are not currently enrolled in the PASARR process):

- Residents for whom two "conditions," as specified in Section A (below) are met;

Or

- Residents for whom one "condition," as specified in Section B (below) is met;

Or

- Residents for whom two "conditions," as specified in Section A and one "condition," as specified in Section B are met.

Section A: SERIOUS MENTAL ILLNESS The individual meets at least *two* of the following "conditions" and is currently not enrolled in e PA SA RR process:

Condition i: S/he is diagnosed with a serious mental illness (see Level I form and page 27 of this manual for a non-inclusive list of SMI examples) or s/he is being prescribed a psychoactive medication (major tranquilizer, neuroleptic, psychotropic, and antidepressant);

and/or

Condition ii: S/he is receiving or has received mental health treatment at a level more intensive than outpatient within the past two years (e.g., inpatient psychiatric hospitalization, partial hospitalization/day treatment) or s/he has exhibited significant psychiatric symptoms within the past two years for which supportive services were required to prevent psychiatric hospitalization or for which judicial or housing intervention resulted.

and/or

Condition iii: S/he has exhibited, due to mental/emotional status, continuing or intermittent difficulty with one or more of the following: developing or sustaining interpersonal relationships, concentrating or completing tasks, or adapting to typical lifestyle changes.

Section B: MENTAL RETARDATION / CONDITIONS The individual meets one of the following "conditions" and is currently not enrolled in the PASARR process:

Condition i: S/he has a diagnosis or behaviors (or other evidence) which suggests the presence of mental retardation and the condition is manifested before the person reaches age 22 (indicators may include a history of receipt of MR services);

and/or

Condition ii: S/he has a diagnosis which is characterized by impairments in adaptive or intellectual functioning (e.g., CP, Autism, Down's syndrome, etc.) and the condition likely developed prior to age 22, and there are substantial functional limitations related to at least 3 of the following: self-care, capacity for independent living, mobility, learning, self direction, understanding/use of language.

Should you have questions about the Level I form, the Quality Review Project, or the PASARR process, contact FMH at (8OO-598-6462) and ask for a North Carolina PASARR reviewer.

SECTION III
INSTRUCTIONS FOR FACILITIES:
LEVEL I SCREENING FORM

III.A INTRODUCTION

The page 22 protocol is the Level I (or *identification screens*) used to determine those individuals who may be subject to a Level II screen under the Federally required Preadmission Screen and Annual Resident Review (PASARR) program. It applies to all nursing facility applicants and residents, regardless of payment source. Swing- beds are currently federally exempt from this process. This form should be completed on all individuals prior to admission to a North Carolina Medicaid certified NF and should be updated whenever there is a significant change in status in a NF resident (see Section I, page 6).

This format is consistent with the recently published federal changes in program requirements. It is expected that the completion time will be slightly longer than with previous procedures; however, this added time should be effective in reducing the number of unnecessary screens and additional delays in placement. The majority of screens will require only the completion of the front page, as information on the reverse is necessary only for those nursing facility (NF) applicants/residents who appear to be mentally ill and/or mentally retarded. Referral sources that are mailing the Level I form for pre admission screens (PAS) should complete the front page on all individuals and should proceed with the second page for those individuals suspected as possibly Ml or MR/RC. For referral sources mailing the form for annual resident reviews (ARRs), information should be provided through Section III (Dementia Screen; page 2) and information should be completed for the legal representative and the primary physician. The following instructions should be used as a guideline for completion:

PT NAME/SS#/MID
Identify the full name of the applicant/resident; the applicant/resident's social security number, and the applicant/resident's Medicaid number. Indicate "N/A" if the individual has not applied for or is not receiving Medicaid benefits.

ADDRESS IN CARE OF
Identify the address and contact person to which correspondence regarding the individual should be directed.

SEX /DOB/COUNTY/PAYMENT STATUS/MARITAL STATUS
Identify the individual's sex as "M" (male) or "F" (female); identify the individual's date of birth, current county of residence, payment status, and marital status.

SOURCE NAME/ADDRESS/PHONE/FACILITY
Identify the name of the individual referring the applicant/resident for a Level I screen; Identify the address, phone, and the facility at which the referral source is employed.

ADMITTING FACILITY/ADDRESS/CONTACT PERSON/PHONE
Identify the name, address, contact person, and phone for the admitting facility, if identified. If not known or identified, indicate as "unknown."

PATIENT'S CURRENT ADDRESS
Indicate the full address of the individual's current residence. If an on-site screen (Level II) is required, this should reflect the location at which the screen will occur. If the patient is currently in the hospital, identify the name, address and room number of that setting.

SECTION I: MENTAL ILLNESS SCREEN

1. A) Psychiatric diagnoses: Begin by checking any applicable diagnoses provided in that block. If the individual is diagnosed with psychiatric conditions not included in the check-list, write those diagnoses in the space provided.

1. B) Psychiatric Meds/Diagnosis/Purpose: Indicate any psychotropic medications (include tranquilizers and antidepressants) which the individual routinely receives. If the individual typically is prescribed a medication within that drug group and it has been temporarily discontinued (e.g., because s/he is in the hospital), that drug should be noted. Diagnosis/Purpose refers to the condition for which that medication is being prescribed.

FMH USE ONLY: Should not be completed by the referral source. FMH clinicians will determine whether, based on information provided by the referral source, the identified diagnosis is consistent with the parameters of the federal requirements for a disabling mental illness.

2. A) **Psychiatric treatment received in the past two years*: indicate any mental health/psychiatric intervention in which the individual has participated in the previous two years, along with specific dates for those services. Inpatient psychiatric hospitalization refers to hospital treatment in a psychiatric facility or a general hospital psychiatric unit; partial hospitalization/day treatment refers to a participation in a structured, outpatient group program of a least three hours per day for a specified number of days per week; "other" refers to any alternative mental health/psychiatric services, to include psychiatric consultations, group therapy, individual therapy, etc.

2. B) *lntervention to prevent hospitalization*: indicate whether, in the absence of psychiatric treatment, the individual has been "at risk" for intense psychiatric treatment because of a mental illness. The services/conditions included in this section refer to services/conditions which are typical of the seriously mentally ill population as a result of the chronicity of the illness. Supportive living (boarding home, group home, supervised living, etc) refers to settings designed or monitored by the mental health system as a result of the individual's symptomatology; housing intervention/legal intervention refers to systemic intervention resulting from the individual's psychiatric status/condition; suicide attempt/other refers to any other conditions/symptoms which may have resulted from the individual's mental illness and, therefore, put him/her at risk for psychiatric hospitalization (although such hospitalization may never have occurred).

*If the referral source is unable to obtain this in formation (from the family, guardian, or the individual) and, based on the individual's behavior, diagnosis, and/or symptoms, such a history is suspected, the referral source should indicate that "no in formation is available, rather than responding "no" to the questions regarding treatment history.

FM/-I USE ONLY: Should not be completed by the referral source. FMH psychiatric nurses will determine, based on supplied information, whether the individual meets federal criteria regarding psychiatric treatment history.

3) *Role Limitations within the past 6 months and due to the mental illness*: Each of the three categories (3.A. through 3.C) are to be rated according to their presence/absence within the past 6 months. Each of these sections should be rated according to the impact the mental illness (or psychiatric symptoms), if present, has on the evaluated issue and should not be rated with respect to the impact of a physical illness or diagnosis. If the individual presents with some of the symptoms/behavioral problems, not related to a physical condition, and s/he has no diagnosis of mental illness, the individual should still be rated.

3. A) Interpersonal Relationships: Circle F, O, or N to indicate *frequently, occasionally, or never*, respectively. Any behavioral/symptomatic conditions which are observed by the referral source, facility, and/or family and are not noted in the supplied list should be written in the space provided.

3. B) Concentration/task limitations: See instructions for 3.A. This area is rating the individual's ability to concentrate/complete tasks, as impacted by his/her emotional status (not related to physical condition).

3. C) Significant problems adapting to typical changes within the past 6 months and due to MI: Circle Y or N to indicate yes or no, respectively. This area is rating the individual's response to any recent lifestyle changes and whether that response may be indicative of or consistent with a serious mental illness.

FMH USE ONLY: Should not be completed by the referral source. FMH psychiatric nurses will determine, based on provided information, whether the individual's functional status is consistent with a psychiatric

disability as defined in federal rules. Combined, the responses to questions 1 through 3 will determine whether the individual meets the federal "seriously mentally ill" definition.

SECTION II: MENTAL RETARDATION AND RELATED CONDITIONS SCREEN

1. A) *MR Diagnosis*: Check V (yes) or N (no) to indicate whether the individual is diagnosed with mental retardation. Specify whether the level of retardation is mild, moderate, severe, or profound, if known. If this information is unavailable, indicate "UK" for unknown.

1. B) *Undiagnosed but suspected MR*: If the individual has not been diagnosed with mental retardation (but such a condition is suspected) or the referral source is uncertain as to whether or not such a diagnosis has been assigned (but suspects that it may be appropriate), the referral source should check "Y" to indicate that suspicion. If 1.A was checked "Y," it will not be necessary to answer 1.B, because the suspicion has already been confirmed through a diagnosis.

1. C) *History of receipt of MR services*: If the individual has received services from a developmental disabilities program or from other MR affiliates, indicate "Y" and specify the type(s) of services.

2. A) *Diagnoses which impair intellectual functioning or adaptive behavior*: This question, along with questions 3 and 4, is determining whether the individual falls within the parameters of a condition related to mental retardation ("related condition"), meaning that an individual with such a condition may need treatment similar to that of a person with mental retardation. There are a number of diagnoses/conditions which are considered related, to include those listed (CP, autism, complicated epilepsy), as well as other conditions such as post encephalitis (prior to age 22), head trauma (prior to age 22), etc. If the referral source is unsure about a diagnostic inclusion in this category, list any suspected related conditions and FMH clinicians will make the determination.

3) *Substantial functional limitations in 3 or more of the following areas*: This question refers to whether the diagnosis/condition has severely impacted functional areas which are similar to the functional impact found with typical MR individuals.

4) *Was the condition manifested before age 22*: Was the identified condition congenital or developed at any time during the developmental period (e.g., head injury, encephalitis)? Individuals whose condition occurred prior to age 22, and who meet criteria for numbers 2 and 3 (above), meet the definition for MR and/or RC and are therefore eligible for various treatment services provided by the State.

FMH Use Only: Do not complete this section. FMH will determine, based on information supplied, whether the individual appears to meet federal criteria for MR/RC.

If the referral source is mailing the protocol information for a PAS, and there is any suspicion of Ml or MR/RC, please complete the reverse section of the form, if the referral source is mailing the information for an ARR, complete the form through Section III (Dementia screen) and complete mailing information for the individual's legal representative and primary physician.

If the individual is found not to require a Level II (by the FMH nurse), FMH will assign an authorization number. For Medicaid individuals, the referral source should then contact EDS to review the FL2 for a level of care determination and to communicate the assigned FMH number. EDS will assign a prior approval number which will continue to be the Medicaid billing number.

SECTION III: DEMENTIA

If the individual appears to be subject to a Level II screen, the dementia section determines whether the individual is eligible for other alternatives as per Level II federal requirements. MI individuals may be exempt if the diagnosis can be corroborated and can be determined as primary,' ("primary" implies that the symptoms of the dementia supersede symptoms of any concurrent psychiatric condition). MR individuals may be eligible for a more abbreviated screen, based upon an analysis of the presenting data.

A) Does the individual have a primary diagnosis of dementia or Alzheimer's disease? This is asking two questions: Does the individual have such a diagnosis? Is that diagnosis primary? The physician should determine whether the dementing condition (if present) is primary, meaning that the dementia symptoms supersede the symptoms/behaviors of the MI/MR.

B) Does the individual have any other organic disorders? This is referring to v there is another organic condition for which the presenting symptoms/behaviors may be attributed.

C) Is there evidence of undiagnosed dementia or other organic mental disorders? Although the individual may not be diagnosed with dementia or a like disorder, this question is asking whether there are presenting symptoms consistent with such a diagnosis.

D) Is there evidence of affective symptoms which might be confused with dementia? It is often very difficult to make a differential diagnosis between dementia and some psychiatric conditions which might mimic dementia (e.g., depression). This question is asking whether some of the presenting symptoms are affective (emotionally based) in nature, possibly indicating a potential for confusion between dementia and another psychiatric condition.

E) Can the facility supply any corroborative information to affirm that the dementing condition exists and is the primary diagnosis? The federal rules require that states must make a reasonable effort to confirm this information before applying any exemptions or categorical determinations for persons with suspected dementia. This is primarily to assure that the intended target populations are evaluated as needed and to prevent inappropriate exemption of individuals who have serious Ml which might be confused with dementia. Examples of the types of information required to confirm such a diagnosis are listed.

FMH Use Only: Do not complete this section. If the individual appears to meet the parameters of primary dementia and s/he is also MI, then the process may cease at this point (meaning that the individual may not require a Level II evaluation). If the individual is also MR/RC, the process should continue. FMH will determine whether an on-site Level II is required, based on data submitted by the facility.

SECTION IV CONVALESCENT CARE EXEMPTION

Convalescent care allows the individual to be placed in a NF for 30 calendar days without performance of a Level II. However, several pro visions apply and <u>all of these</u> must be met before the individual can be admitted under this exemption (see below). FMH will assign an authorization number to individuals approved through this exemption and, for Medicaid individuals; this number should be communicated to EDS following the Level I. At that time, EDS will review the FL2 to determine level of care needs. It is the receiving facility's responsibility to re-establish contact with FMH prior to the conclusion of the 30 calendar days <u>and no later then the 25th calendar day</u> to update the individual's Level I screen if s/he is expected to remain beyond that time.

A) Does the individual meet all of the following criteria?

1) Admission to a NF directly from a hospital: (the individual must be in the hospital at the time of application);

2) Need for NF care is required for the condition for which care was provided in the hospital;

3) The attending physician has certified prior to admission that the individual will require less than 30 days NF care (and this 30 day certification is provided to FMH at the time of the screen). Clearly, an individual whose medical condition will require longer than 30 days stabilizing will not be eligible for convalescent care (broken hip) and should not apply for this exemption.

SECTION V: CATEGORICAL DETERMINATIONS

5.1; A-C Categories listed under number one of section 5 (A-C) allow for temporary admission (7 calendar days) of MI/MR individuals who meet certain criteria. It is the responsibility of the referral source to contact FMH prior to admission to complete appropriate protocols. If the individual is determined to meet the categorical determination standards, the referral source will be provided an FMH authorization number. Following receipt of this number, EDS should be contacted for Medicaid individuals to review the FL2 and to communicate the assigned number. If at any time it appears that the individual's stay may exceed 7 calendar days, and no later than the 5th calendar day, the receiving facility must update screens as follows: Contact FMH to update the Level I and initiate the Level II. Following completion of the Level II, a new authorization number will be provided. For Medicaid individuals, that number should then be communicated to EDS during the level of care review. Information in Sections IV and V are required only for preadmission screens (PAS).

A) *Emergency*: Refers to immediate need for placement as a protective service measure. This standard applies if:

a. based on the MI/MR individual's physical and/or environmental status; there is a sudden and unexpected need for immediate NF placement;

And

b. the above need requires temporary 7 day placement until alternative services/placement can be secured and no other placement options are available.

B) *Delirium*: A condition whereby the presence of delirious state precluded the ability of the referral source to determine Level I measures and there is a subsequent need to allow the delirium to clear before proceeding with that screen.

C) *Respite*: Temporary (7 day) care for an individual with MI/MR to allow respite for the caretaker to w the individual will return following the temporary stay.

FMH Use Only: Do not complete this section. FMH will determine, based on provided information, whether the individual meets criteria for a categorical determination. FMH will supply an expiration date to correlate with the determination. <u>It is the responsibility of the receiving facility to update appropriate screens if at any time it appears the individual's stay will exceed 7 calendar days and no later than the 5th calendar day from admission</u>

5.2 *The category listed under number two of this section allows for a decision that a person with diagnoses of both MR/AC and dementia, depending on the progression of the dementia, may not benefit from specialized services. By federal rule, a decision for medical eligibility must still be made for the individual. Therefore, the FMH nurse will also request medical information to determine whether NF placement is appropriate. If a decision for appropriate placement cannot be made with that information, the screen must proceed to number three of this section. If a decision is made that placement is appropriate, the individual will not require a face-to-face Level II.*

5.3; A-D of this section determines whether a decision for medical eligibility may be made on a categorical basis. If any of the four options are checked, the following outcomes will occur:

1) For individuals meeting both number 2 (dementia and MR/RC) and an option in number 3, then s/he does not require a face-to-face Level II evaluation. FMH nurses will provide preliminary treatment recommendations, as per federal requirements, in the section which states: "*For individuals meeting categorical determinations for which further evaluation is not required, the following recommendations are provided*." Persons determined to meet 3.B. will be assigned an end-date (60 days) which will require that the Level I screen be re initiated if the individual's stay is expected to exceed that time. The facility is responsible for initiating this update no later than 50 days after admission. Other categories (e.g., terminal illness, severe medical condition, and coma) will be tracked by FMH and will not require an update by the facility, unless a significant change in the individual's mental health/mental retardation treatment needs occurs.

2) For individuals meeting A-C of section 3, a face-to-face Level II evaluation will be required to determine specialized service needs. Again, the 30 - 60 day convalescence will be provided an “end date” that must be monitored by the facility. This screen must be updated prior to the conclusion of the time period and no later than the assigned end date.

3) For individuals meeting 3.D, a face Level II will not be required.

MAILING INFORMATION

This information should be completed for all individuals.

FMH SUMMARY

This section will be completed by FMH to provide a synopsis of the Level I screen results. Verbal determinations will be provided to the referral source upon completion of the form and/or receipt of any requested corroborative data. The receiving facility must contact FMH to receive a copy of this form. This signed and dated form will be mailed to the receiving facility following that contact and should be kept in the individual’s permanent medical record. This form should be transferred with the individual if s/he relocates and will not require an update unless there has been a significant change in status or unless the individual was approved under a categorical or convalescent admission. A description of status changes and time limited approvals which warrant Level I updates is provided in Section I of this manual.

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NORTH CAROLINA LEVEL I SCREENING FORM
THIS MUST REMAIN IN THE INDIVIDUAL'S RECORD

Patient Name: _____ SS #: _____

Address: c/o _____ MID #: _____ Sex: _____

_____ DOB: _____ Pmt. Status: _____ Marital Status: _____

_____ Original Admit Date: _____ Admit Date: _____

County: _____ Admitting Facility: _____

Source Name: _____ Address: _____

Address: _____ Contact Person: _____

Telephone: _____ Telephone: _____

Facility: _____ Patient's Current Address: _____

_____

SECTION I: MENTAL ILLNESS SCREEN

1.A. Psychiatric Diagnoses

_____

_____

_____

☐ Anxiety/panic disorder ☐ Psychotic disorder
☐ Bipolar Disorder ☐ Somatoform disorder
☐ Delusional Disorder ☐ Schizophrenia
☐ Schizoaffective disorder ☐ Eating disorder(specify)
☐ Major depression _____
☐ Personality disorder (specify) _____

1.B. Psychiatric Meds — Diagnosis/Purpose

_____ _____
_____ _____
_____ _____
_____ _____

FMH USE ONLY: **Meets diagnosis criteria for chronicity?** ☐ Y ☐ N ☐ UTD

2.A. Psychiatric treatment received in past 2 years:
☐ inpatient psych. hosp.(dates) _____
☐ partial hosp./day treatment(dates) _____
☐ other(dates) _____

2.B. Intervention to prevent hospitalization:
☐ supportive living due to MI(dates) _____
☐ housing intervention due to MI(dates) _____
☐ legal intervention due to MI(dates) _____
☐ suicide attempt(dates) _____
☐ other _____

FMH USE ONLY: **Meets criteria for duration:** ☐ Y ☐ N ☐ UTD

3. Role limitations in past 6 months due to MI:
Indicate: "F" Frequently, "O" Occasionally, or "N" Never

3. A. Interpersonal Functioning (exclude problems w/medical basis)

F O N Altercations
F O N Evictions
F O N Fear of strangers
F O N Suicidal talk
F O N Illogical comments
F O N Other_____
F O N Social isolation/avoidance
F O N Excessive irritability
F O N Easily upset/anxious
F O N Hallucinations
F O N Serious communication difficulties
F O N Other_____

Notes: _____

3.B. Concentration/task limitations within past 6 months and due to MI (exclude problems with medical basis):

F O N Serious difficulty completing age related tasks.
F O N Serious loss of interest in things.
F O N Serious difficulty maintaining concentration/ attention.
F O N Numerous errors in completing tasks which s/he should be physically capable.
F O N Requires assistance with tasks for which s/he should be physically capable of accomplishing.
F O N Other_____

Notes: _____

3.C. Significant problems adapting to typical changes within 6 months and due to MI (exclude problems with medical basis):

Y N Requires mental health intervention due to increased symptoms.
Y N Requires judicial intervention due to symptoms.
Y N Symptoms have increased as a result of adaptation difficulties.
Y N Serious agitation or withdrawal due to adaptation difficulties.
Y N Other _____

Notes: _____

FMH USE ONLY:
Meets criteria for disability: ☐ Y ☐ N ☐ UTD
MI Decision: Meets criteria for SMI: ☐ Y ☐ N ☐ UTD

SECTION II: MENTAL RETARDATION AND RELATED CONDITIONS SCREEN

1.A. MR diagnosis: ____N ____Y (specify) _____
B. Undiagnosed but suspected MR: ____N ____Y ____N/A
C. History of receipt of MR services: ____N ____Y
(if yes, specify): _____

2. Occurrence before age 22: ____N ____Y
(if yes, specify age): _____

3.A. Diagnoses which impair intellectual functioning or adaptive behavior.
____Cerebral Palsy ____Autism ____Epilepsy
____Organic brain syndrome ____Other_____

B. Substantial functional limitations in 3 or more of the following:
____Self-care ____Mobility ____Learning
____Self-direction ____Capacity for independent living
____Understanding/use of language

C. Was the condition manifested before age 22?
____N ____Y (specify) _____

FMH USE ONLY: **Meets criteria for MR/RC**
MR Decision: ☐ Y ☐ N ☐ UTD

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LEVEL I SCREENING FORM CONTINUED ON NEXT PAGE

CONFIDENTIAL

Patient Name: _____

S.S.#: _____

STOP HERE IF MI & MR DECISIONS ARE BOTH "NO". OTHERWISE CONTINUE.

SECTION III: DEMENTIA (complete for both MI & MR)

A. Does the individual have a primary diagnosis of Dementia or Alzheimer's Disease?
____ Y ____ N (specify)_____

B. Does the individual have any other organic disorders?
____ Y ____ N (specify)_____

C. Is there evidence of undiagnosed Dementia or other organic mental disorders?
Y N disoriented to time Y N disoriented to situation
Y N disoriented to place Y N pervasive, significant confusion
Y N severe ST memory deficit Y N paranoid ideation

D. Is there evidence of affective symptoms which might be confused with Dementia?
Y N frequent tearfulness Y N severe sleep disturbance
Y N frequent anxiety Y N severe appetite disturbance

E. Can the facility supply any corroborative information to affirm that the dementing condition exists and is the primary diagnosis?
____ Dementia work-up ____ Thorough mental status exam
____ Medical/functional history prior to onset of dementia
____ Other_____

FMH USE ONLY:
Does the individual have a primary dementia diagnosis?
Dementia decision: ☐ Y ☐ N ☐ UTD

IF "YES" FOR MI PATIENT, STOP HERE. CONTINUE FOR ALL MR/RC PATIENTS AND FOR MI PATIENTS WHO DID NOT MEET DEMENTIA EXEMPTION.

SECTION IV: CONVALESCENT CARE EXEMPTION *

A. Does the admission meet all of the following criteria?
____ Admission to a NF directly from a hospital after receiving acute medical care in the hospital; and
____ Need for NF care is required for the condition for which care was provided in the hospital; and
____ The attending physician has certified prior to NF admission that the individual will require less than 30 days NF services.

*** Individuals meeting all criteria are exempt for Level II screens for 30 days. The receiving facility must update Level I screen at such time that it appears the individual's stay will exceed 30 days and no later than the 25th day.**

FMH USE ONLY:
Meets convalescent exemption: ☐ Y ☐ N
Expiration Date: _____ STOP HERE IF "YES".

SECTION V: CATEGORICAL DETERMINATIONS *

1. *The following decisions indicate the individual does meet NF eligibility and does not require specialized services for the time limit specified. An updated Level I Screen is required if the stay is expected to exceed 7 days & no later than the 5th day.
A. ____ emergency protective service situation for MI/MR individual needing 7 day NF placement.
B. ____ Delirium precludes the ability to accurately diagnose. An updated Level I is required at such time that the delirium clears and/or no later than 5 calendar days from admission.
C. ____ respite is needed for in-home caregivers to whom the MI/MR individual will return within 7 days.

FMH USE ONLY: If yes, receiving facility must update Level I prior to following expiration date for residents expected to remain past 7 days: _____

2.** ____ MR/RC with concurrent primary dementia marked by ST and LT memory loss with impairments in judgement and abstract thought to the extent that specialized services could not be beneficial.

FMH USE ONLY: Meets categorical SS determination:
A. ☐ N ☐ UTD ☐ Yes **If so, complete B
B. Appropriate for N. ☐ N ☐ UTD ☐ Yes
If yes, no Level II required. If no, proceed to 3.

3. The following determine that the individual requires NF care.
***Further evaluation requirements are specified below.
A. ____ Terminal illness with life expectancy of 6 months or less.
B. ____ Convalescence from a hospital stay for an acute medical condition which requires 30-60 days care in a NF setting. The individual is not a danger to self or others.
C. ____ Severe medical condition (ALS, Huntington's, ventilator dependence, CHF, COPD, Parkinson's, Advanced M.S., MD, cerebral degeneration, CVA, End stage renal disease, severe diabetic neuropathies, quadriplegia, refractory anemias).
D. ____ Coma or persistant vegetative state.

FMH USE ONLY:
*****1. Meets categorical eligibility determination in conjunction with Dementia MR/RC (specify end date when using 3B.)**
☐ N ☐ UTD ☐ Yes; does not require a face to face Level II evaluation but will be subject to ARRs
*****2. Meets categorical eligibility determination only**
☐ N ☐ UTD ☐ Yes; will require a face to face Level II to determine specialized service needs
*****3. Meets coma or persistent vegetative state**
☐ N ☐ UTD ☐ Yes; will not require a face to face Level II but will be subject to ARRs.

For individuals meeting categorical determination(s) for which further evaluation (Level II) is not required, the following service recommendations are provided: _____

Mailing Information:
Legal representative's name and address:

_____

_____

_____

Primary physician's name and address:

_____

_____

_____

ATTACH ANY ADDITIONAL NOTES ON A SEPARATE PAGE.

FMH SUMMARY (OFFICE USE ONLY)
____ Level I approved ____ Requires Level II psychiatric
____ Requires Level II MR/RC
____ Requested information to aid in determination:
____ Level II required ____ Level II not required
____ Time limited approval (expiration date_____)
____ Status change:
____ Early ARR required ____ Early ARR not required

_____
FMH Reviewer Signature

_____
Date

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SECTION IV
GENERAL INFORMATION

IV.A REPORTS/COORDINATION OF PASARR AND NF PROCESSES

A verbal response to the Level I determination will be provided to the referral source at the time that the assessment is completed or within a maximum of 24 hours of receipt of any additional information requested by the FMH Level I nurses. Written notification will be forwarded to nursing facilities (and other appropriate parties), following telephone contact or receipt of the tracking form from the admitting facility indicating the admission date. If admission is denied as a result of the Level II process, written notification will be automatically provided to the individual and his/her legal guardian, along with appeals rights through the fair hearing process.

Reports from Level II evaluations will also be forwarded to nursing facilities and must be maintained in the individual's medical record so that they remain accessible to facility staff. PASARR reports are required to identify both specialized service needs and treatment needs which fall below the level of specialized services, if appropriate. These determination reports work in conjunction with the facility's initial and annual *resident assessment* process to define a holistic care plan for the resident.

Facilities must maintain these reports (Level I and Level II, as applicable) in the evaluated individual's permanent medical record and should transfer this data with the resident if s/he relocates. As indicated on page 7, please report transfers, discharges, and deceased Level II residents to FMH so that tracking for subsequent ARRs can occur.

IV.B QUALITY ASSURANCE

As required by the NC Division of Medical Assistance, FMH will randomly request back-up documentation from facilities after completing a telephone review. This request will not delay the telephone review decision, but will provide the information needed to monitor the integrity of the telephone review process. Requested documents may be sent by mail or by FAX to the FMH office. Quality assurance staff will independently review the records submitted and prepare reports of the accuracy of the telephone review process. Consistent facility variance between information given by telephone and the record documentation may trigger additional training for that facility or, if the variances persist despite training, telephone based review for that facility may be terminated.

IV.C DEFINITIONS

A. ANNUAL RESIDENT REVIEW - An extended annual assessment of nursing facility residents with serious mental illness, mental retardation, or conditions related to mental retardation to determine level of care needs and special treatment needs. As per federal regulations, ARRs must be performed annually. Annually is federally defined as occurring within the quarter of the anniversary date of the previous Level II.

B. CHANGE IN STATUS A condition which warrants referral for an updated Level I screen, to include: A) Significant change in medical status of an MI or MR/RC individual, such that mental health/mental retardation needs may be affected; 2) Discovery of an MI or MR/RC individual who has not been previously identified in the PASARR process; 3) Exacerbation of symptoms or behaviors related to MI or MR/RC which may reflect a change in mental health treatment needs. The MDS/resident assessment process should be used to "trigger" an updated Level I referral as these conditions emerge or are discovered.

C. ELECTRONIC DATA SYSTEMS (EDS) - The Division of Medical Assistance's fiscal agent, responsible for determining level of care for Medicaid recipients and applicants. EDS should be contacted following completion of the Level I or Level II screen (as appropriate) to complete the level of care determination and to obtain a prior approval number. At that time, the referral source should provide EDS with the authorization number provided by FMH.

D. LEVEL I SCREEN - An assessment conducted prior to admission to a Medicaid certified NF, or when there is indication of a resident's change in status, to determine presence of serious mental illness, mental retardation, or conditions related to mental retardation. Swing-beds are currently exempt from both the Level I and Level II processes.

E. LEVEL II SCREEN - An extended clinical assessment of an individual who shows significant signs and symptoms of mental illness or mental retardation/related conditions in order to determine treatment and placement needs. Level II Screens include direct clinical assessment of the individual, record review, and psychiatric or mental retardation professional feedback through a summarized evaluation report.

F. MENTAL RETARDATION (MR)/RELATED CONDITIONS (RC) - Sub average general intellectual functioning (mild, moderate, severe, profound) existing concurrently with deficits in adaptive behavior and manifesting during the developmental period; or a severe, chronic disability whose condition is related to mental retardation (see Related Condition).

G. NF LEVEL OF CARE DETERMINATION - An assessment of an applicant or resident of a nursing facility to determine if s/he meets minimum Medicaid medical necessity requirements for nursing facility care. These screens are performed by EDS on Medicaid applicants and recipients after the Level I or, if applicable, Level II process. For persons requiring a Level II, appropriateness of placement will be determined during the Level II evaluation. If placement is determined as appropriate, EDS should then be contacted for Medicaid applicants/recipients to determine level of care.

H. REFERRAL SOURCE - Person assisting applicant with nursing facility placement (i.e. hospital discharge planner, nursing facility admissions coordinator, county case worker, home health worker).

I. RELATED CONDITIONS/RC (TO MENTAL RETARDATION) - Severe, chronic disability whose condition is: (a) attributable to: Cerebral palsy or epilepsy; or any other condition, other than MI, found to be closely related to MR because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with MR and requires treatment or services similar to those required for such persons (i.e., autism); (b) manifested before the person reached age 22; (c) likely to continue indefinitely; (d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living

J. SERIOUS MENTAL ILLNESS - A condition which results in the presence of the following: A) A DSM-III-R diagnosis of a mental disorder which is likely to lead to a chronic disability, excluding a primary diagnosis of dementia or a related disorder; and B) Presence of functional disabilities within the past 6 months which are inconsistent with the individual's developmental stage and medical condition and include deficits in one of the following: interpersonal functioning, concentration/task performance, or adaptation to change; and C) Treatment history within the past 2 years which includes either psychiatric treatment more intensive than outpatient or supportive services (to include judicial or housing intervention) to prevent need for more intensive services.

K. SPECIALIZED SERVICES/MI - A continuous and aggressive implementation of an individualized plan of care that: is developed under and supervised by a physician with an interdisciplinary team of qualified mental health professionals; prescribes services for treatment of persons experiencing an acute episode of serious MI, which requires 24-hour supervision by trained mental health personnel, and; is directed toward diagnosing and reducing the person's psychotic symptoms in order to permit reduction of the intensity of mental health services to below the level of specialized services.

L. SPECIALIZED SERVICES/MR AND RC - May be provided for individuals determined by the Level II evaluation as needing an aggressive, continuous program of active treatment as would be available in an ICF/MR. These services do not include those services otherwise provided by a NF (which include special rehabilitation services such as speech therapy, occupational therapy, physical therapy, etc.).

M. SWING-BED ADMISSIONS - Applicants for swing-bed admission are not subject to Level I/Level II screens.

PSYCHIATRIC DISORDERS WHICH MAY LEAD TO CHRONIC DISABILITY (non-inclusive)

BY DIAGNOSTIC CODE

295.10-295.95 Schizophrenic disorders and schizoaffective disorder

296.32-296.34 Major depression, recurrent, with moderate, severe, and/or psychotic features

296.40-296.70 Bipolar disorders

297.10 Delusional disorder

297.30 Induced psychotic disorder

298.90 Psychotic disorder NOS

300.01 Panic disorder, without agoraphobia

300.02 Generalized anxiety disorder

300.11 Conversion disorder

300.12 Psychogenic amnesia

300.13 Psychogenic fugue

300.14 Multiple personality disorder

300.15 Dissociative disorder NOS

300.21 Panic disorder, with agoraphobia

300.22 Agoraphobia without history of panic disorder

300.30 Obsessive compulsive disorder

301 .00 Paranoid personality disorder

301.20 Schizoid personality disorder

301.22 Schizotypal personality disorder

301.40 Obsessive compulsive personality disorder

301 .50 Histrionic personality disorder

301.81 Narcissistic personality disorder

301.83 Borderline personality disorder

307.10 Anorexia nervosa

307.51 Bulimia nervosa

309.89 Post traumatic stress disorder

ALPHABETICAL (NON-INCLUSIVE)

Agoraphobia without history of panic disorder

Anorexia nervosa

Bipolar disorders

Bulimia nervosa

Conversion disorder

Delusional disorder

Dissociative disorder NOS

Generalized anxiety disorder

Induced psychotic disorder

Major depression, recurrent, with moderate, severe, and/or psychotic features

Multiple personality disorder

Narcissistic personality disorder

Obsessive compulsive disorder

Obsessive compulsive personality disorder

Panic disorder, without agoraphobia

Panic disorder, with agoraphobia

Personality disorders (paranoid, borderline, histrionic, schizoid, schizotypal)

Post traumatic stress disorder

Psychogenic amnesia

Psychogenic fugue

Psychotic disorder NOS

Schizophrenic disorders and schizoaffective disorder

(For PASARR purposes, final rules do **not** include organic disorders as reflective of a serious mental illness).

MEDICAID BULLETIN
No. 154
April 1991

12- Attention: OSS placement staff, LTC providers, and hospital discharge planners
FL-2s for prior approval

In an effort to appropriately perform the long term care (LTC) prior approval process, it is necessary that submitted FL-2s be legible and complete. FL-2s that are illegible or incomplete (with missing information) will be returned. Strict adherence to the following guidelines will eliminate the need for EDS to return FL-2s to the county offices.

1. If FL-2 information is telephoned to EDS, the call must be made by staff with medical backgrounds. This may include: social workers (county, CAP/DA, or CAP/C, facility or hospital), income maintenance caseworkers, nurses, physicians, or nursing home administrators. It is not appropriate for the recipient, the recipient's representative, or any individual without knowledge of the recipient's medical condition to contact EDS. -

2. The FL-2 must include current and pertinent information.

3. All three copies of the FL-2 must be mailed to EDS. The information must be legible on all copies.

4. All FL-2s for prior approval must be sent through the county department of social services in the recipient's county of residence.

5. FL-2s must be signed and dated by the attending physician, validating the care needs of the recipient, before approval is requested.

6. FL-2s with altered dates will not be accepted. If such an error occurs, a new FL-2 must be completed with a signature and current signature date prior to submission.

7. The date shown on the FL-2 must be complete (MMDDYY). For an FL to be considered current, the telephone or written request must be made to EDS within 30 days from the date of the physician's signature.

8. Telephone-approved FL-2s are valid pending the receipt of the original FL-2 within 10 working days. Approval will be voided if the written FL-2 is not received within the specified time limit, and if the information received is not consistent with information previously telephoned to EDS.

9. For FL-2s that have been denied for the recommended level of care, and no further supporting documentation is to be submitted, the lower level of care will be approved and a number assigned. The approved lower level of care is contingent upon receipt of the original FL-2 within 15 working days.

10. The recipient's Medicaid ID number must be indicated on the FL-2 when it is submitted.

11. All current medical information justifying the level of care requested must be shown on the FL-2. For assistance, refer to Sections 4300.-4300.5, 4301.1-4301.5, and 4601.-4603 of the Long Term Care Provider Manual.

EDS

1-800-366-3373 or 919-851-8888

Published by E.D.S. Federal Corporation fiscal agent for the North Carolina Medicaid Program

1-800-366-3373 or 919-851-8888

SECTION .2400- ADMISSION POLICIES 1

.2401 ADMISSIONS

(a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs.

(b) Exceptions. People are not to be admitted for:

(1) for treatment of mental illness, or alcohol or drug abuse;

(2) for maternity care;

(3) for professional nursing care under continuous medical supervision;

(4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or

(5) who pose a direct threat to the health or safety of others.

History Note: Filed as a temporary amendment Eff October 14, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Statutory Authority G.S. 131D-2: 143B-153:
Eff January 1, 1977;
Readopted Eff October31, 1977;
Amended Eff February 1. 1993; April 1, 1992; July 1, 19k), January 1. 1989.

.2402 MEDICAL EXAMINATIONS

(a) Each resident shall have a medical examination and be tested for tuberculosis disease before admission and annually thereafter. Tests for tuberculosis disease shall comply with the control measures adopted by the Commission for Health Services as specified in 15A NCAC 19A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Environment, Health, and Natural Resources, Tuberculosis Control Branch, Post Office Box 27687, Raleigh, North Carolina 27611-7687.

(b) The results of the complete examination are to be entered on Form FL-2 or MR-2. The examining date recorded on the FL-2 or MR-2 must be no more than 90 days prior to the person's admission or readmission to the home. The FL-2 or MR-2 must be in the facility before admission or readmission or accompany the resident upon admission or readmission and be reviewed by the administrator or supervisor-in-charge before admission or readmission. If the information on the form is not clear or is insufficient, the administrator or supervisor-in-charge must contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. The completed Form FL-2 or MR-2 must be filed in the resident's record in the home.

(c) The administrator must make arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated, using Form DSS- 1867 or an equivalent record.

History Note: Statutory Authority G. S. 131D-2; 143B-153,
Eff January 1, 1977,
Readopted Eff October 31, 1977•
Amended Eff December 1, 1993; July 1, 1990 April 1, 1987; April 1, 1984.

.2403 OBTAINING INORMATION

History Note: Statutory Authority G. S. 131D-2; 143B-153;
Eff January 1, 1977;
Readopted Eff October 31, 1977,

.2404 RESIDENT REGISTER

(a) Before or at admission, the administrator or supervisor-in-charge, and the resident or his responsible person shall complete and sign the Resident Register (Form DSS-1865). Special instructions for the completion of several items on the Resident Register are:

(1) name, address and telephone number of the resident's physician. If a resident does not have a personal physician, arrangements must be made by the administrator with the resident, his responsible person or social worker to have a physician before admission; and

(2) personal information from the resident, his responsible person and social worker. This must at least include information about the resident's ties to the community, his preferences for food and activities, and his capabilities and capacity for self-care.

(b) The administrator or supervisor-in-charge must revise the completed Resident Register (Form DSS- 1865) with the resident or his responsible person as needed.

History Note: Statutory Authority G. S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1. 1984.
.2405 INFORMA11ON ON HOME

At admission, the administrator or supervisor-in-charge must furnish and review with the resident or his responsible person essential information on the home. A statement indicating that this information has been received is to be signed and dated by each person to whom it is given. This statement must be retained in the resident's record in the home. The information must at least include:

(1) a copy of the home's resident contract specifying rates for resident services and accommodations;

(a) The contract must be signed and dated by the administrator or supervisor-in-charge and the resident or his responsible person and a copy given to the resident or his responsible person;

(b) The resident or his responsible person must be notified as much in advance as possible of any rate changes or other changes in the contract affecting the resident services and accommodations and be provided an amended copy of the contract for review and signature;

(c) A copy of each signed contract must be kept in the resident's record in the home;

(d) Gratuities in addition to the established rates shall not be accepted; and

(e) The maximum monthly rate for domiciliary care that may be charged to public assistance recipients is established by the North Carolina Social Services Commission or the General Assembly;

(2) a written copy of any house rules, including the conditions for the discharge and transfer of residents, the refund policies, and the home's policies on smoking, alcohol consumption and visitation. The resident or his responsible person must be promptly notified of any change in the house rules and provided an amended copy. All house rules must be consistent with the rules in this Subchapter;

(3) a copy of the Domiciliary Home Residents' Bill of Rights;

(4) a copy of the home's grievance procedures which must indicate how the resident is to present complaints and make suggestions as to the home's policies and services on behalf of himself or others; and

(5) a statement as to whether the home has signed Form DSS-1464, assuring compliance with Title VI of the Civil Rights Act. This statement must also indicate that if the home does not choose to comply or is found to be

in non-compliance the residents of the home would not be able to receive State-County Special Assistance for Adults and the home would not receive supportive services from the county department of social services.

History Note: Statutory Authority G. S. 131D-2; 143B-153
Eff April 1, 1984,
Amended Eff July 1, 1990; April 1, 1987.

SECTION .2500 - DISCHARGE POLICIES

.2501 OTHER LIVING ARRANGEMENTS

The administrator must discuss with the resident and his responsible person the need to make other plans for the resident when:

(1) The resident's physician indicates the resident's condition has improved to the point he can live outside a domiciliary facility with family or community support services;

(2) The resident's physician certifies that the resident needs professional nursing care or intermediate care under medical supervision. In this situation, plans for other placement must be made as soon as possible and the county department of social services will assist the administrator or resident in making arrangements for necessary care when requested;

(3) The resident's condition is such that he is a danger to himself or poses a direct threat to the health or safety of others;

(4) The resident makes a written request or otherwise indicates an earnest desire to transfer to another licensed home; and

(5) The resident's adjustment to the home is not satisfactory as determined by the administrator and the resident or his responsible person. This is only to be done after a reasonable period of time during which the resident was provided help with adjusting to the home. It is the responsibility of the administrator to contact the resident's responsible person and the county department of social services and request assistance to help the resident in adjusting. This request is to be made at the first indication of an adjustment problem.

History Note: Statutory Author G. S. 131D-2 143B-153;
Eff January 1, 1977;
Readopted Eff October 31, 1977;
Amended Eff December 1, 1993, July 1. 19k April 1, 1987; April 1, 1984.

.2502 NOTIFICATIONS TO FAMILY OR AGENCY

.2503 PROCEDURES OF DISCHARGE

History Note: Statutory Authority G. S. 131D-2 143B-153;
Eff January 1, 1977;
Readopted Eff October 31, 1977;
Repealed Eff April 1, 1984.

.2504 ADJUSTMENTS TO NEW HOME

History Note: Statutory Authority G.S. 131D-2; 143B-1S3;
Eff January 1, 1977;
Readopted Eff October 31. 1977;
Amended Eff April 1. 1984;
Repealed Eff July 1. 19

.2505 REQUIREMENTS FOR DISCHARGE OR TRANSFER

(a) When a discharge or transfer is initiated by the home, the administrator must provide the resident, his family or responsible person and the county department of social services with two weeks (14 days) advance written notification citing the reason for the discharge or transfer.

(b) When a discharge or transfer is initiated by the resident or his responsible person, the resident or his responsible person is to provide the administrator with two weeks (14 days) advance written notification.

(c) Exceptions to the required notice are cases where a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the home.

(d) The discharge or transfer of any resident is prohibited if it would violate the titles of this Subchapter or the Domiciliary Home Residents' Bill of Rights, General Statute 131D-21.

(e) The date of the discharge or transfer and the reason for the move are to be recorded on the Form DSS-1865, the Resident Register.

History Note: Statutory Authority G. S. 131D-2; 143B-153;
Eff January 1, 1977;
Readopted Eff October 31, 1977;
Amended Eff July 1. 19%; April 1, 1987; April 1, 1984.

CHANGES IN SITUATION
PART TWO - PROCEDURES

III. SPECIAL PROVISION FOR CONTINUATION OF SPECIAL ASSISTANCE WHEN THE LEVEL OF CARE IS UPGRADED BUT NO BED IS AVAILABLE

When an FL-2/MR-2 indicates that a recipient's recommended level of care has been upgraded, you must:

A. Make a referral to the appropriate services staff informing them of the situation. The appropriate services staff determines whether a bed is available at the appropriate level of care.

B. If a bed is available, send the DSS-8158 and terminate SA benefits. Transfer the case to Medicaid if eligible.

C. If no bed is available at the appropriate level of care, you may continue SA at the current rate until a bed is located.

If there is a bed available but the recipient or representative chooses not to accept it, this special provision is unavailable. The recipient is no longer eligible for SA because he is In an Inappropriate level of care. Stop SA benefits; transfer the case to M-AABD if eligible

D. Required Documentation

1. File the FL-2/MR-2 in the case record.
2. Document in the case record:
    a. Date you received an FL-2IMR-2; and
    b. Date of the FL-2/MR-2 and recommended level of care on the FL-2/MR-2; and
    c. Date you made a referral to the appropriate services' staff; and
    d. That a bed at the recommended level of care is not available; and
    e. That SA continues 1ll a bed is located; and
    f. Your monthly contacts with the appropriate services staff regarding the placement progress. (See Figure 3220-2 for a suggested documentation format on these cases.)
3. These cases are reflected on the monthly Case Management Report. (See SA-3280 and EIS 3102 for instructions on flagging cases in EIS.) Review placement progress with the appropriate services staff each month until the recipient is placed.

Document specifically the following information each month:

a. Date of contact with and name of the appropriate services staff assigned to the case; and
b. What progress has been made in locating a bed at the appropriate level of care?

E. Monitoring

Monitor these cases to ensure that a bed at the appropriate level of care is located as quickly as possible and that the length of time the recipient is covered under this special provision is kept to a minimum.

DOCUMENTATION REGARDING CONTINUATION OF SPECIAL ASSISTANCE WHEN THE LEVEL OF CARE IS UPGRADED, BUT NO BED AVAILABLE

Case Name _____ Date _____

County Case/Dist. No. _____ Case ID _____

Ind ID _____

1. Upgraded FL-2/MR-2 dated: _____ Received: _____

2. Recommended level of care: _____

3. Date you or services staff notified of the upgraded FL-2/MR-2: _____

4. Is a bed available at the upgraded level of care? ___ yes ___ no

If yes, terminate SA benefits. Transfer the case to M-AABD, if appropriate.

If no, go to next step.

5. Monthly Placement Progress Notes

DATE OF CONTACT WITH SERVICES STAFF	NAME OF SERVICES STAFF	PLACEMENT NOTES	CASEWORKER'S INITIALS

CHAPTER 24- SOCIAL SERVICES: GENERAL
SUBCHAPTER 24B - CONFIDENTIALITY AND ACCESS TO CLIENT RECORDS
SECTION .0100 - GENERAL PROVISIONS

.0101 PURPOSE

History Note: Statutory Authority G.S. 108A-80; 143B-153;
Eff October 1, 1981;
Repealed Eff March 1, 1990

.0102 DEFINITIONS

As used in this Subchapter, unless the context clearly requires otherwise, the following terms have the meanings specified:

(1) “Client’ means any applicant for, or recipient of, public assistance or services, or someone who makes inquiries, is interviewed, or is or has been otherwise served to some extent by the agency. For purposes of this Subchapter, someone acting responsibly for the client in accordance with agency policy is subsumed under the definition of client.

(2) “Agency” means the state Division of Social Services and the county departments of social services, unless separately identified.

(3) “Client information” or “client record” means any information, whether recorded or not and including information stored in computer data banks or computer files, relating to a client which was received in connection with the performance of any function of the agency.

(4) “Director” means the head of the state Division of Social Services or the county departments of social services.

(5) “Delegated representative” means anyone designated by the director to carry out the responsibilities established by the rules in this Subchapter. Designation is implied when the assigned duties of an employee require access to confidential information.

(6) “Court order” means any oral order from a judge or a written document from a judicial official which directs explicitly the release of client information.

(7) “Service provider” means any public or private agency or individual from whom the agency purchases services, or authorizes the provision of services provided or purchased by other divisions of the Department of Human Resources.

History Note: Statutory Authority G. S. 108A-80; 143B-153
Eff October 1, 1981.

.0103 INFORMATION FROM OTHER AGENCIES

If the agency receives information from another agency or individual, then such information shall be treated as any other information generated by the state Division of Social Services or the county departments of social services, and disclosure thereof will be governed by any condition imposed by the furnishing agency or individual.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

SECTION .0200 - SAFEGUARDING CLIENT INFORMATION

.0201 CONFIDENTIALITY

History Note: Statutory Authority G. S. 108A -80; 143B-153;
Eff October 1, 1981;
Repealed Eff March 1, 1990.

.0202 CONFLICT OF LAWS

Whenever there is inconsistency between federal or state statutes or regulations specifically addressing confidentiality issues, the agency shall abide by the statute or regulation which provides more protection for the client.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981;
Amended Eff March 1, 1990.

.0203 OWNERSHIP OF RECORDS

(a) All client information contained in any records of the agency is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as provided by the rules of this Subchapter.

(b) Original client records may not be removed from the premises by individuals other than authorized staff of the agency, except by an order of the court.

(c) The agency shall be allowed to destroy records in accordance with Record Retention Schedules promulgated by the Division of Archives and History, rules of the Division of Social Services, and state and federal statutes and regulations.

History Note: Statutory Authority G. S. 108A-80; 143B-153,
Eff October 1, 1981.

.0204 SECURITY OF RECORDS

(a) The agency shall provide a secure place with controlled access for the storage of records. Only employees, students, volunteers or other individuals who must access client information in order to carry out duties assigned or approved by the agency shall be authorized access to the storage area.

(b) Only authorized individuals may remove a record from the storage area and the authorizing individual shall be responsible for the security of the record until it is returned to the storage area.

(c) The agency shall establish procedures to prevent accidental disclosure of client information from automated data processing systems.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981;
Amended Eff March 1, 1990

.0205 ASSURANCE OF CONFIDENTIALITY

The director shall assure that all authorized individuals are informed of the confidential nature of client information and shall disseminate written policy to and provide training for all persons with access to client information.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0206 LIABILITIES OF PERSONS WITH ACCESS TO CLIENT INFORMATION

(a) Individuals employed by the agency and governed by the State Personnel Act are subject to suspension, dismissal or disciplinary action for failure to comply with the rules of this Subchapter.

(b) Individuals other than employees, including volunteers and students who are agents of the Department of Human Resources who have access to client information and fail to comply with the rules in this Subchapter shall be denied access to confidential information and may be subject to dismissal or termination of relationship with the agency.

(c) Individuals other than employees but including volunteers and students who are agents of the Department of Human Resources and who have access to client information shall be liable in the same manner as employees.

History Note: Statutory Authority G.S. 108A-80; 143B -153;
Eff October 1, 1981;
Amended Eff February 1, 1986.

.0301 RIGHT OF ACCESS

Confidentiality of information about himself is the right of the client. Upon written or verbal request the client shall have access to review or obtain without charge a copy of the information in his records with the following exceptions:

(1) information that the agency is required to keep confidential by state or federal statutes or regulations.

(2) confidential information originating from another agency as provided for in Rule .0103 of this Subchapter.

(3) information that would breach another individual's right to confidentiality.

History Note: Statutory Authority G.S. 1O8A- 143B-153;
Eff October 1, 1981.

.0302 PROMPT RESPONSES TO REQUEST

The agency shall provide access as defined in Rule .0301 of this Subchapter as promptly as feasible but no more than five working days after receipt of the request.

History Note: Statutory Authority G. S. 108A-80; 143B-153,
Eff October 1, 1981.

.0303 WITHHOLDING INFORMATION FROM THE CLIENT

(a) When the director or a delegated representative determines on the basis of the exceptions in Rule .0301 of this Subchapter to withhold information from the client record, this reason shall be documented in the client record.

(b) The director or a delegated representative must inform the client that information is being withheld, and upon which of the exceptions specified in Rule .030 1 of this Subchapter the decision to withhold the information is based. If confidential information originating from another agency is being withheld, the client shall be referred to that agency for access to the information.

(c) When a delegated representative determines to withhold client information, the decision to withhold shall be reviewed by the supervisor of the person making the initial determination.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0304 PROCEDURES FOR REVIEW OF RECORDS

The director or his delegated representative shall be present when the client reviews the record. The director or his delegated representative must document in the client record the review of the record by the client.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0305 CONTESTED INFORMATION

A client may contest the accuracy, completeness or relevancy of the information in his record. A correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the director or his delegated representative concurs that such correction is justified. When the director or his delegated representative does not concur, the client shall be allowed to enter a statement in the record. Such corrections and statements shall be made a permanent part of the record and shall be disclosed to any recipient of the disputed information. If a delegated representative decides not to correct contested information, the decision not to correct shall be reviewed by the supervisor of the person making the initial decision.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
NORTH CAROLINA ADMINISTRATIVE CODE 02/15/90
Eff October 1, 1981.

.0306 REVIEW OF RECORD BY PERSONAL REPRESENTATIVES

Upon written request from the client, his personal representative, including an attorney, may have access to review or obtain without charge, a copy of the information in his record. The client may permit the personal representative to have access to his entire record or may restrict access to certain portions of the record. Rules .0301 through .0305 of this Subchapter shall apply.

History Note: Statutory Authority G. S. JOSA-80; 143B -153;
Eff October 1, 1981.

SECTION .0400 - RELEASE OF CLIENT INFORMATION

.0401 PROCEDURES FOR OBTAINING CONSENT FOR RELEASE OF INFORMATION

(a) As a part of the application process for public assistance or services, the client shall be informed of the need for and give consent to the release of information necessary to verify statements to establish eligibility.

(b) As a part of the application process for Aid to Families with Dependent children, and State or County Special Assistance for Adults, the client shall be informed of the requirement for listing of the public assistance recipient's name, address, and amount of the monthly grant in a public record open to public inspection during the regular office hours of the county auditor.

(c) No individual shall release any client information which is owned by the state Division of Social Services or the county departments of social services, or request the release of information regarding the client from other agencies or individuals without obtaining a signed consent for release of information. Disclosure without obtaining consent shall be in accordance with Section .0500 of this Subchapter.

History Note: Statutory Authority G.S. 108A-80; 143B-153,
Eff October 1, 1981;
Amended Eff March 1, 1990.

.0402 CONSENT FOR RELEASE OF INFORMATION

(a) The consent for release of information shall be on a form provided by the state Division of Social Services or shall contain the following:

(1) name of the provider and the recipient of the information;

(2) the extent of information to be released;

(3) the name and dated signature of the client;

(4) a statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent;

(5) length of time the consent is valid.

(b) The client may alter the form to contain other information which may include but is not limited to:

(1) a statement specifying the date, event or condition upon which the consent may expire even if the client does not expressly revoke the consent;

(2) specific purpose for the release.

History Note: Statutory Authority G. S. 108A-8O, 143B-153;
Eff October 1, 1981.

.0403 PERSONS WHO MAY CONSENT TO THE RELEASE OF INFORMATION

The following persons may consent to the release of information:

(1) the client;

(2) the legal guardian if the client has been adjudicated incompetent;

(3) the county department of social services if the client is a minor and in the custody of the county department of social services.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0404 INFORMED CONSENT

Prior to obtaining consent for release of information, the delegated representative shall explain the meaning of informed consent. The client shall be told the following:

(1) contents to be released;

(2) that there is a definite need for the information;

(3) that the client can give or withhold the consent and the consent is voluntary;

(4) that there are statutes and regulations protecting the confidentiality of the information.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0405 PERSONS DESIGNATED TO RELEASE CLIENT INFORMATION

Directors and their delegated representatives, as defined, may release client information in accordance with rules in Section .0400 of this Subchapter.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0406 DOCUMENTATION OF RELEASE

Whenever client information is released on the basis of consent as defined in .0402 of this Subchapter, the director or delegated representative shall place a copy of the signed consent in the appropriate client record.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

SECTION .0500 - DISCLOSURE OF CLIENT INFORMATION WITHOUT CLIENT CONSENT

.0501 DISCLOSURES WITHIN THE AGENCY

(a) Client information from the public assistance record may be disclosed without the consent of the client under the following circumstances:

(1) to other employees of the county department of social services for purposes of making referrals, supervision, consultation or determination of eligibility;

(2) to other county departments of social services when the client moves to that county and requests public assistance;

(3) between the county departments of social services and the state Division of Social Services for purposes of supervision and reporting.

(b) Client information from the service record may be disclosed without the consent of the client under the following circumstances:

(1) to other employees of the county department of social services for purposes of making referrals, supervision, consultation or determination of eligibility;

(2) to another county department of social services when that county department of social services is providing services to a client who is in the custody of the county department of social services;

(3) to another county department of social services to the extent necessary to facilitate the provision of a service requested by referring county department of social services;

(4) between the county department of social services and the state Division of Social Services for purposes of supervision and reporting.

History Note, Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981;
Amended Eff March 1, 1990.

.0502 DISCLOSURE FOR THE PURPOSE OF RESEARCH

Client information may be disclosed without the consent of the client to individuals requesting approval to conduct studies of client records, provided such approval is requested in writing and the written request will specify and be approved on the basis of:

(1) an explanation of how the findings of the study have potential for expanding knowledge and improving professional practices;

(2) a description of how the study will be conducted and how the findings will be used;

(3) a presentation of the individual's credentials in the area of investigation;

(4) a description of how the individual will safeguard information;

(5) an assurance that no report will contain the names of individuals or any other information that makes individuals identifiable.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0503 DISCLOSURE FOR PURPOSES OF ACCOUNTABILITY

Client information may be disclosed without the consent of the client to federal, state, or county employees for the purpose of monitoring, auditing, evaluating, or facilitating the administration of other state and federal programs, provided that the need for the disclosure of confidential information is justifiable for the purpose and that adequate safeguards are maintained to protect the information from re-disclosure.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981;
Amended Eff March 1, 1990.

.0504 DISCLOSURE PURSUANT TO OTHER LAWS

Client information may be disclosed without the consent of the client for purposes of complying with other state and federal statutes and regulations.

History Note: Statutory Authority G. S. 108A-80; 143B-153,
Eff October 1, 1981.

.0505 DISCLOSURE PURSUANT TO A COURT ORDER

Client information may be disclosed without the consent of the client in response to a court order, as defined.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0506 NOTICE TO CLIENT

When information is released without the client's consent, the client shall be informed to the extent possible, of the disclosure. The method of informing the client of the disclosure shall be documented in the appropriate record.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0507 DOCUMENTATION OF DISCLOSURE

Whenever client information is disclosed in accordance with Section .0500 of this Subchapter, the director or delegated representative shall ensure that documentation of the disclosure is placed in the appropriate client record.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0508 PERSONS DESIGNATED TO DISCLOSE INFORMATION

Directors and their delegated representatives, as defined, may disclose client information in accordance with Section .0500 of this Subchapter.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

SECTION .0600 - SERVICE PROVIDERS

.0601 INFORMATION NEEDS OF SERVICE PROVIDERS

(a) Agencies may disclose client information to other service providers, as defined, only to the extent necessary to determine the service requirements and to meet the needs of the client, and to the extent necessary to provide eligibility information for reporting purposes.

(b) The client shall be informed and consent to the disclosure of this information in accordance with the rules of this Subchapter.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0602 CONTRACT RESTRICTION

As a part of every contract for the purchase of services, the service provider will agree to restrict the use or disclosure of information obtained in connection with the administration of the state's programs for the provision of services concerning clients to purposes directly connected with the administration of the service program.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0603 ASSURANCE OF CONFIDENTIALITY

(a) The county department of social services shall disseminate written policy and assure that all private agency and individual service providers from whom they purchase services are informed of the confidential nature of client information.

(b) Public agency service providers shall abide by written policy promulgated by their cognizant state agency, if any. If written policy has not been issued, Paragraph (a) of this Rule shall apply.

(c) The Department of Human Resources shall disseminate written policy and assure that all service providers from whom the county departments of social services authorize the provision of services to clients understand the confidential nature of client information.

History Note. Statutory Authority G. S. 108A-80, 143B-153;
Eff October 1, 1981.

.0604 OWNERSHIP OF RECORDS

(a) All client information contained in records of the service provider is the property of the service provider, and the service provider and employees of the service provider shall protect and preserve such information in accordance with the terms of their contract.

(b) Any information furnished by the county department of social services shall be protected from re-disclosure.

History Note: Statutory Authority G. S. 108A-80; 143B-153;
Eff October 1, 1981.

.0605 LIABILITY OF SERVICE PROVIDERS

Failure to comply with the rules in Section .0600 of this Subchapter shall constitute a breach of contract and shall be grounds to terminate the contract.

History Note: Statutory Authority G. S. 1O8A-8O, 143B-153,
Eff October 1, 1981.

2 ADULT PLACEMENT JOB DESIGN

	TIME	OCCURRENCE	TIME EARNED	20/80	TIME CONSUMING TASKS
27 Check on Medicaid/SA applications/ authorizations	4.00	56.50%	2.26	0.0194	2.26
28 Gather supplies, pencil, paper	1.43	100.00%	1.43	0.0123	
29 Locate forms	2.00	100.00%	2.00	0.0172	
30 Complete/Update Face Sheet	3.50	98.75%	3.46	0.0297	3.46
31 Complete DSS-5027 application for services	10.00	85.00%	8.50	0.0730	8.50
32 Walk to copy machine	0.98	5.00%	0.05	0.0004	
33 Make copies	0.81	5.00%	0.04	0.0003	
34 Walk from copy machine	0.98	5.00%	0.05	0.0004	
35 Sort Information	0.64	100.00%	0.64	0.0055	
36 Walk to supervisor's office	0.40	10.00%	0.04	0.0003	
37 Impromptu conference with supervisor	9.41	10.00%	0.94	0.0081	
38 Walk from supervisor's office	0.40	10.00%	0.04	0.0003	
39 Phone call to co-worker	2.85	63.75%	1.82	0.0156	
40 Walk to co-worker's office	0.33	4.50%	0.01	0.0001	
41 Consultation with co-worker	15.00	4.50%	0.68	0.0058	
42 Walk from co-workers office	0.33	4.50%	0.01	0.0001	
43 Phone call to Central/Regional DSS office	15.00	0.50%	0.08	0.0006	
44 Telephone call to/from hospital social worker	8.16	26.25%	2.14	0.0184	2.14
45 Telephone call to/from facility administration and staff	9.00	5.00%	0.45	0.0039	
46 Set up case record	4.66	46.25%	2.16	0.0185	2.16
47 Preparation for dictation/documentation	6.19	100.00%	6.19	0.0532	6.19
48 Dictate/document (inc. 1325)	9.05	100.00%	9.05	0.0778	9.05
49 Organize record	2.39	85.00%	2.03	0.0175	2.03
50 Filing, any kind, anywhere	0.66	100.00%	0.66	0.0057	
51 Prepare routing slip	1.17	40.00%	0.47	0.0040	
52 Type or write notes to others	2.62	100.00%	2.62	0.0225	2.62
53 Type or write notes to self	1.95	100.00%	1.95	0.0168	
54 Walk to transfer referral/application package for assignment and return	1.00	75.50%	0.76	0.0065	

I ADULT PLACEMENT JOB DESIGN

		TIME	OCCURRENCE	TIME EARNED	TOTAL TIME EARNED FOR FUNCTION (Minutes)	TOTAL TIME EARNED FOR SVC. ELEMENT (INCL GA)	20/80	TIME CONSUMING TASKS
	INTAKE							
	Preparation/Engagement (Before Interview)							
1	Phone call from reference/reception	0.68	78.75%	0.54			0.0046	
2	Receive and review written referral	2.00	21.25%	0.43			0.0037	
3	Telephone call to file room/reception	2.75	18.75%	0.52			0.0044	
4	Check client history on terminal	3.00	65.00%	1.95			0.0168	
5	Travel to/from file room/reception	1.00	33.00%	0.33			0.0028	
6	Brief attempt to look for record	7.00	15.00%	1.05			0.0090	
7	Read/Review record	3.00	29.75%	0.89			0.0077	
8	Travel to Supervisor's office	0.40	1.00%	0.00			0.0000	
9	Wait	3.67	0.50%	0.02			0.0002	
10	Impromptu Conference	9.41	0.50%	0.05			0.0004	
11	Travel from Supervisor's office	0.40	1.00%	0.00			0.0000	
12	Phone call to reference/client	0.64	15.25%	0.10			0.0008	
13	Gather Intake forms (5027,1325)	2.00	100.00%	2.00			0.0172	
14	Sign out/Program phone/tell receptionist	0.58	13.25%	0.08			0.0007	
15	Travel to get client/representative	0.50	50.75%	0.25			0.0022	
16	Travel from reception	1.25	50.75%	0.63			0.0055	
17	Greet/receive/engage	1.50	50.75%	0.76	9.60		0.0065	
	Interview Client/Representative (Telephone or office or home)							
18	Gathering and Giving information (inc. face sheet and problem identification)	18.08	100.00%	18.08			0.1553	18.08
19	Counseling	14.11	100.00%	14.11			0.1212	14.11
20	Closure of Interview/make referrals	9.00	100.00%	9.00			0.0773	9.00
21	Give release of information and DSS/5027	3.26	85.00%	2.77			0.0238	2.77
22	Return client to lobby	1.25	45.25%	0.57			0.0049	
23	Return to office	0.50	45.25%	0.23			0.0019	
24	Sign in; check messages	1.13	13.25%	0.15	44.90		0.0013	
	Terminate Intake (After Interview)							
25	Look for lost record	34.80	9.00%	3.13			0.0269	3.13
26	Request, find, get ID Number	2.00	41.25%	0.83			0.0071	

3 ADULT PLACEMENT JOB DESIGN

	TIME	OCCURRENCE	TIME EARNED	TOTAL TIME EARNED FOR FUNCTION (Minutes)	TOTAL TIME EARNED FOR SVC. ELEMENT (INCL. GA)	20/80	TIME CONSUMING TASKS
56 Address envelope	1.17	5.00%	0.06			0.0005	
57 Walk to/from mailbox and mail item	2.18	5.00%	0.11			0.0009	
58 Interruptions	1.40	100.00%	1.40			0.0120	
					116.40 Minutes		85.50
				56.04	1.94 Hours		73.45%

4 ADULT PLACEMENT JOB DESIGN

	ASSESSMENT OF NEEDS AND SUPPORTIVE COUNSELING	TIME	OCCURRENCE	TIME EARNED	TOTAL TIME EARNED FOR SVC. ELEMENT (INCL. GA)	20/80	TIME CONSUMING TASKS
1	Obtain record	15.00	7.50%	1.13		0.0155	
2	Review existing service record/ intake materials	3.00	25.00%	0.75		0.0103	
3	Telephone income maintenance caseworker	1.50	25.00%	0.38		0.0052	
4	Check terminal for client history/ eligibility	3.00	40.00%	1.20		0.0165	
5	Telephone client/family/referral source for information	6.94	100.00%	6.94		0.0954	6.94
6	Call to establish appointment time for a field visit	1.50	95.00%	1.43		0.0196	
7	Gather supplies, program phone, walk to reception, sign out	2.50	95.00%	2.38		0.0326	
8	Additional contact to gain entry	8.00	5.00%	0.40		0.0055	
9	Greet/Receive/engage	0.17	95.00%	0.16		0.0022	
10	Conduct Assessment, including six functional areas and problems/strengths	42.08	95.00%	39.98		0.5495	39.98
11	Counseling	4.11	95.00%	3.90		0.0537	
12	Closure of Interview	9.00	95.00%	8.55		0.1175	8.55
13	Sign in; check messages	1.13	95.00%	1.07		0.0148	
14	Walk to supervisor's office	0.40	10.00%	0.04		0.0005	
15	Impromptu conference with supervisor	9.41	8.00%	0.75		0.0103	
16	Walk from supervisor's office	0.40	10.00%	0.04		0.0005	
					72.75 Minutes		55.47
					1.21 Hours		76.24%

5 ADULT PLACEMENT JOB DESIGN

SERVICE PLANNING	TIME	OCCURRENCE	TIME EARNED	TOTAL TIME EARNED FOR SVC. ELEMENT (INCL. GA)	20/80	TIME CONSUMING TASKS
1 Telephone call to establish appointment	1.50	20.00%	0.30		0.0041	
2 Gather supplies, program phone, walk to reception, sign out	2.50	20.00%	0.50		0.0069	
3 Review assessment information and review/identify problems and strengths	3.00	95.00%	2.85		0.0522	
4 Determine client's and representatives' expectations/needs	4.00	95.00%	3.80		0.0653	
5 Review daily routines in long term care facility	5.00	95.00%	4.75		0.1306	9.50
6 Explain levels of care, costs, facilities, process of being approved for Medicaid/Special Assistance, needed forms, FL-2/PASAAR, and what to expect on yearly basis	10.00	95.00%	9.50		0.1306	9.50
7 Counseling	10.00	95.00%	9.50		0.1306	9.50
8 Establish goals, strategies, responsible persons with/client and resp. party	10.00	95.00%	9.50		0.0000	
9 Documentation of service plan	5.00	95.00%	4.25		0.0584	
10 Sign in; check messages	1.13	10.00%	0.11	47.45 Minutes 0.79 Hours		28.50 60.07%

	TIME	OCCURRENCE	TIME EARNED	20/80	TIME CONSUMING TASKS
PRE-PLACEMENT PROCEDURES					
1 Arrange transportation to other services	10.00	8.00%	0.80	0.0113	
2 Telephone calls to other agencies	7.94	28.75%	2.28	0.0322	
3 Gather supplies, program phone, walk to reception, sign out	2.50	51.25%	1.28	0.0181	
4 Accompany client to other services (FL-2, spend down assets, personal property disposition)	120.00	11.25%	13.50	0.1903	13.50
5 Take FL-2/PASAAR I to doctor/ Pick up completed FL-2/PASAAR I	30.00	45.00%	13.50	0.1903	13.50
6 Review FL-2/PASAAR I to be sure it is complete	1.77	100.00%	1.77	0.0250	
7 Sign in, check messages	1.13	50.00%	0.57	0.0080	
8 Call Doctor for incomplete FL-2/PASAAR I	16.67	38.75%	6.46	0.0911	6.46
9 Check on Medicaid/Special Assistance applications/authorizations	2.50	99.25%	2.48	0.0350	
10 Make application for client	60.00	7.50%	4.50	0.0634	4.50
11 Initiate referrals and/or forms for clients who need prostheses, DME's, appliances, services, etc.	45.00	2.25%	1.01	0.0143	
12 Complete all/part of PASAAR I	20.00	21.25%	4.25	0.0599	4.25
13 Call Doctor to clarify indication/ need for PASAAR II	20.00	4.38%	0.88	0.0123	
14 Call client/family to explain need for PASAAR II evaluation	12.31	0.16%	0.02	0.0003	
15 Call Mental Health/arrange appointment	11.17	2.88%	0.32	0.0045	
16 Call client/family to notify of appointment	6.94	2.83%	0.20	0.0028	
17 Gather supplies, program phone, walk to reception, sign out	2.50	2.70%	0.07	0.0010	
18 Accompany and participate with client in mental health visit	80.00	2.70%	2.16	0.0305	2.16
19 Sign in; check messages	1.13	2.70%	0.03	0.0004	
20 Call Mental Health to secure PASAAR II	11.17	0.50%	0.06	0.0008	
21 Review PASAAR II	1.77	0.50%	0.01	0.0001	
22 Call to Income Maintenance re: PASAAR II	4.26	0.50%	0.02	0.0003	
23 Call EDS Federal	30.00	21.25%	6.38	0.0899	6.38

7 ADULT PLACEMENT JOB DESIGN

	TIME	OCCURRENCE	TIME EARNED	TOTAL TIME EARNED FOR SVC. ELEMENT (INCL. GA)	20/80	TIME CONSUMING TASKS
24 Walk to/from copy machine	1.96	100.00%	1.96		0.0276	
25 Make copies	0.81	100.00%	0.81		0.0114	
26 Address envelope	1.17	85.00%	0.99		0.0140	
27 Walk to/from outgoing mail; mail	2.18	85.00%	1.85		0.0261	
28 Call doctor	5.00	0.25%	0.01		0.0002	
				70.93 Minutes		50.74462
				1.18 Hours		71.54%

					20/80	TIME CONSUMING TASKS
	LOCATING BED AND SECURING PLACEMENT					
1	Check on Medicaid/SA applications/ authorizations	6.67	100.00%	6.67	0.0316	6.67
2	Gather supplies, program phone, walk to reception, sign out	2.50	2.50%	0.06	0.0003	
3	Research court records	40.00	2.50%	1.00	0.0047	
4	Sign in; check messages	1.13	2.50%	0.03	0.0001	
5	Telephone calls internal to/from DSS	1.64	200.00%	3.28	0.0155	
6	Telephone calls to/from client/caretaker	6.94	200.00%	13.88	0.0658	13.88
7	Telephone calls to/from collaterals/agen	7.94	8.75%	0.69	0.0033	
8	Telephone calls to/from facilities	9.96	400.00%	39.84	0.1888	39.84
9	Walk to/from co-worker's office	0.66	37.50%	0.25	0.0012	
10	Consultations (in person) internal to DS	15.00	37.50%	5.63	0.0267	5.63
11	Travel to and from reception	3.52	3.25%	0.11	0.0005	
12	Call to establish appointment with client/representative	26.67	15.75%	4.20	0.0199	
13	Gather supplies, program phone, walk to reception, sign out	2.50	15.75%	0.39	0.0019	
14	Conferences (in person) with client/ representative (office or home); (can be contact for quarterly review)	26.67	19.00%	5.07	0.0240	5.07
15	Sign in; check messages	1.13	13.25%	0.15	0.0007	
16	Call to establish appointment with collateral/agency	4.33	2.75%	0.12	0.0006	
17	Gather supplies, program phone, walk to reception, sign out	2.50	2.75%	0.07	0.0003	
18	Consultations (in person) with collateral/agency staff	23.33	2.75%	0.64	0.0030	
19	Sign in, check messages	1.13	2.75%	0.03	0.0001	
20	Call to establish appointment	4.33	2.75%	0.12	0.0006	
21	Gather supplies, program phone, walk to reception, sign out	2.50	2.75%	0.07	0.0003	
22	Consultations (in person) with facility staff	23.33	2.75%	0.64	0.0030	
23	Sign in, check messages	1.13	2.75%	0.03	0.0001	
24	Interruptions from co-worker	1.40	81.25%	1.14	0.0054	
25	Type/write notes to others	3.85	75.00%	2.89	0.0137	

				20/80	TIME CONSUMING TASKS
26 Type/write notes to self	3.85	100.00%	3.85	0.0182	
27 Calls to establish appointment with facility and client	16.90	26.75%	4.52	0.0214	
28 Gather supplies, program phone, walk to reception, sign out	2.50	26.75%	0.67	0.0032	
29 Take client/representative on pre-placement visit	40.00	26.75%	10.70	0.0507	10.70
30 Sign in, check messages	1.13	26.75%	0.30	0.0014	
31 Travel to supervisor's office	0.40	10.00%	0.04	0.0002	
32 Impromptu conference	9.41	10.00%	0.94	0.0045	
33 Travel from supervisor's office	0.40	10.00%	0.04	0.0002	
34 Confirm available placement (telephone call)	9.96	100.00%	9.96	0.0472	9.96
35 Instruct aide to shop for/with client	4.00	2.75%	0.11	0.0005	
36 Gather supplies, program phone, walk to reception, sign out	2.50	3.13%	0.08	0.0004	
37 Shop for client	50.00	3.13%	1.56	0.0074	
38 Sign in; check messages	1.13	3.13%	0.04	0.0002	
39 Call to establish appointment with client	6.94	3.01%	0.21	0.0010	
40 Gather supplies, program phone, walk to reception, sign out	2.50	3.01%	0.08	0.0004	
41 Shop with client	100.00	3.01%	3.01	0.0143	
42 Sign in; check messages	1.13	3.01%	0.03	0.0002	
43 Call to establish appointment/admission	6.94	75.75%	5.26	0.0249	5.26
44 Gather forms, program phone, go to reception and sign out	2.50	38.75%	0.97	0.0046	
45 Assist client in packing	93.3	16.00%	14.93	0.0707	14.93
46 Accompany client to facility for admission	20.00	16.25%	3.25	0.0154	
47 Supportive counseling at admission	40.00	38.75%	15.50	0.0734	15.50
48 Participate in admissions process	26.67	38.75%	10.33	0.0490	10.33
49 Sign in; check messages	1.13	36.25%	0.41	0.0019	
50 Prepare for dictation/documentation	7.92	100.00%	7.92	0.0375	7.92
51 Dictate/Document (inc. documentation of quarterly review)	13.73	100.00%	13.73	0.0651	13.73

10 ADULT PLACEMENT JOB DESIGN

				TOTAL TIME EARNED FOR SVC. ELEMENT (INCL. GA)	20/80	TIME CONSUMING TASKS
52 Placement notice sent to appropriate others	5.00	100.00%	5.00		0.0237	5.00
				211.06 Minutes		164.41
				3.52 Hours		77.90%

					20/80	TIME CONSUMING TASKS
POST-PLACEMENT ADJUSTMENT (Low-intensity)						
1 Gather supplies, program phone, walk to reception, sign out	2.57	47.50%	1.22		0.0114	
2 Assess client's adjustment to placement (can be contact for quarterly review)	15.00	47.50%	7.13		0.0668	7.13
3 Counseling with client and/or family	14.00	47.50%	6.65		0.0624	6.65
4 Mediate between client and facility re: concerns since placement	10.00	8.50%	0.85		0.0080	
5 Assist client in giving facility a written notice if leaving facility	15.00	0.50%	0.08		0.0007	
6 Review appropriateness of facility's discharge/notice procedure to client	10.00	0.50%	0.05		0.0005	
7 Sign in; check messages	1.13	47.50%	0.54		0.0050	
8 Initiate referals and/or forms for clien need prostheses, DME's, appliances, services, etc.	40.00	2.00%	0.80		0.0075	
9 Telephone calls internal to DSS	6.00	20.25%	1.22		0.0114	
10 Telephone calls to client, family, friends, agencies, etc.	10.00	190.00%	19.00		0.1782	19.00
11 Telephone calls to facility	8.23	100.00%	8.23		0.0772	8.23
12 Walk to and from co-worker's office	0.66	15.50%	0.10		0.0010	
13 Consultation (in person) internal to DSS	15.00	15.50%	2.33		0.0218	
14 Gather supplies, program phone, walk to reception, sign out or travel to/from reception	2.50	15.00%	0.38		0.0035	
15 Conferences (in person) with client, family, friends, etc. (OV or HV)	10.00	15.00%	1.50		0.0141	
16 Sign in, check messages	1.13	10.00%	0.11		0.0011	
17 Call to establish appointment	4.00	10.03%	0.40		0.0038	
18 Gather supplies, program phone, walk to reception, sign out or travel to/from reception	2.50	10.50%	0.26		0.0025	
19 Consultations (in person) with facility staff/collaterals/agencies	30.00	10.50%	3.15		0.0295	3.15
20 Sign in, check messages	1.13	8.25%	0.09			
21 Interruptions by anyone	1.40	75.00%	1.05		0.0098	

				TOTAL TIME EARNED FOR SVC. ELEMENT (INCL. GA)	20/80	TIME CONSUMING TASKS
22 Type/write notes to others	3.85	75.00%	2.89		0.0271	2.89
23 Type/write notes to self	3.85	100.00%	3.85		0.0361	3.85
24 Complete case contact log	1.00	250.00%	2.50		0.0234	
25 Walk to/from another office	0.80	10.00%	0.08		0.0008	
26 Case staffing (internal)	15.00	10.00%	1.50		0.0141	
27 Multidisciplinary team staffing (interagency)	40.00	1.00%	0.40		0.0038	
28 Compose and process correspondence	35.00	0.50%	0.18		0.0016	
29 Walk to copy machine	0.98	0.25%	0.00		0.0000	
30 Make copies	0.81	0.25%	0.00		0.0000	
31 Walk from copy machine	0.98	0.25%	0.00		0.0000	
32 Walk to/from outgoing mail; mail	2.18	0.50%	0.01		0.0001	
33 Filing	0.66	400.00%	2.64		0.0248	
34 Make and receive intra-agency referrals	11.65	1.00%	0.12		0.0011	
35 Review case information and document decision regarding continued need for service or termination (includes documentation of quarterly review)	21.77	100.00%	21.77		0.2041	21.77
36 Walk to supervisor's office	0.40	100.00%	0.40		0.0038	
37 Impromptu conference	9.41	100.00%	9.41		0.0882	9.41
38 Walk from Supervisor's office	0.40	100.00%	0.40		0.0038	
				106.64 Minutes		82.07
				1.78 Hours		76.96%

					20/80	TIME CONSUMING TASKS
POST-PLACEMENT ADJUSTMENT (High-intensity)						
1 Gather supplies, program phone, walk to reception, sign out	2.50	200.00%	5.00		0.0179	
2 Assess client's adjustment to placement (can be contact for quarterly review)	15.00	47.50%	7.13		0.0256	
3 Counseling with client and/or family	22.50	200.00%	45.00		0.1614	45.00
4 Mediate between client and facility re: concerns since placement	22.50	175.00%	39.38		0.1412	39.38
5 Assist client in giving facility a written notice if leaving facility	15.00	5.00%	0.75		0.0027	
6 Review appropriateness of facility's discharge/notice procedure to client	10.00	2.75%	0.28		0.0010	
7 Sign in; check messages	1.13	200.00%	2.26		0.0081	
8 Initiate referrals and/or forms for clie need prostheses, DME's, appliances, services, etc.	60.00	50.00%	30.00		0.1076	30.00
9 Telephone calls internal to DSS	6.00	37.50%	2.25		0.0081	
10 Telephone calls to client, family, friends, etc.	10.00	200.00%	20.00		0.0717	20.00
11 Telephone calls to facility	8.23	200.00%	16.46		0.0590	16.46
12 Walk to and from co-worker's office	0.66	30.00%	0.20		0.0007	
13 Consultation (in person) internal to DSS	15.00	30.00%	4.50		0.0161	
14 Gather supplies, program phone, walk to reception, sign out or travel to/from reception	2.50	100.00%	2.50		0.0090	
15 Conferences (in person) with client, family, friends, etc. (OV or HV)	37.50	100.00%	37.50		0.1345	37.50
16 Sign in, check messages	1.13	52.50%	0.59		0.0021	
17 Call to establish appointment	4.00	7.50%	0.30		0.0011	
18 Gather supplies, program phone, walk to reception, sign out or travel to/from reception	2.50	7.50%	0.19		0.0007	
19 Consultations (in person) with facility staff/collaterals/agencies	30.00	7.50%	2.25		0.0081	
20 Sign in, check messages	1.13	5.00%	0.06		0.0002	
21 Interruptions by anyone	1.40	87.50%	1.23		0.0044	
22 Type/write notes to others	3.85	75.00%	2.89		0.0104	

Intake, Assessment, Service Planning, Pre-placement Procedures, Locating Bed and Securing Placemen 591.45 Minutes (Incl. GA)
9.86 Hours (Incl. GA)

To this total, add either 106.64 minutes for low intensity adjustment per month case is open;
or 278.84 minutes for high intensity adjustment per month case is open

QUALITY AND TIMELINESS ASSURANCE TOOL
ADULT PLACEMENT SERVICES

SOCIAL WORKER:_____ CLIENT NAME:_____
SUPERVISOR:_____ CASE NUMBER:_____
DATE OF REVIEW:_____ PERIOD: From_____ To_____

	QUALITY POINTS			TIMELINESS POINTS		
	Avail.	Applic.	Earned	Avail.	Applic.	Earned
I. Intake						
A. Client's functional problems and circumstances are documented and reflect:						
1. When the problem(s) presented and what events surrounded it	2	____	____			
2. Interventions tried and their effect	2	____	____			
3. Client/representative's perception of the problem and what he/she believes will solve it	2	____	____			
B. Documentation indicates how the criteria in the service target population was met	6	____	____			
C. Face Sheet (or equivalent) is:						
1. current	1	____	____			
2. accurate	1	____	____			
D. Release of Information is:						
1. complete	5	____	____			
2 accurate	5	____	____			
E. SIS Client Entry Form (DSS-5027) is:						
1. complete	2	____	____			
2. accurate	2	____	____			
3. completed within 30 days of request for service				3	____	
4. copy given/sent to client within 15 calendar days of eligibility determination or 30 days of application, whichever comes first				3	____	
F. Service is provided within 15 calendar days of date the notice of eligibility was sent to client.				3	____	____
SUBTOTALS	28			9		

	QUALITY POINTS			TIMELINESS POINTS		
	Avail.	Applic.	Earned	Avail.	Applic.	Earned
II. Assessment of Needs and Supportive Counseling						
A. Documentation reflects that assessment of six functional areas, including strengths and limitations, was conducted						
1. social	1	____	____			
2. environmental	1	____	____			
3. mental	1	____	____			
4. physical	1	____	____			
5. ADL's/IADL's	1	____	____			
6. economic	1					
B. Client is seen personally to do the assessment unless documentation reflects the client is not in the county, it is an emergency situation, or an original assessment is available to update.	6					
C. Documentation includes information about other agencies or service providers known to be involved with client	6					
SUBTOTALS	18					

III. Service Planning						
A. Documentation reflects development of a service plan with the client (if client has the capability to do so) and family/representative;						
1. Goals are set	2	____	____			
2. Tasks/activities/services needed to reach goals are determined	2	____	____			
3. Persons responsible for tasks are identified and their agreement secured	2	____	____			
4. Service plan is appropriate based on problems, strengths and goals identified.	2					
B. Documentation reflects client's and/or family's reactions to placement.	6					
C. Client agrees to plans for placement (if he/she has the capability)	10					
D. Documentation reflects how services are being coordinated so as not to duplicate services	6					
SUBTOTALS	30					

	QUALITY POINTS			TIMELINESS POINTS		
	Avail.	Applic.	Earned	Avail.	Applic.	Earned
IV. Pre-placement Procedures						
A. Documentation reflects that client/family was appropriately assisted (as indicated in the service plan) in meeting requirements for:						
1. FL-2 or MR-2	10	____	____			
2. PASARR 1/PASARR 2	10	____	____			
3. Medicaid/Special Assistance Eligibility	10					
B. FL-2/MR-2 information is called in or FL-2/MR-2 is mailed so that it is received by EDSF for prior approval (ICF, SNF, ICF/MR) within 30 days of physician's signature date				10		
C. Telephone-approved FL-2/MR-2 is forwarded to EDSF within 10 working days of call-in				6		
D. Copy of the approved FL-2/MR-2 stamped by EDSF is provided to income maintenance in a timely manner upon agency receipt				6		
E. FL-2/MR-2 and PASARR copies are filed in case record	2					
SUBTOTALS	32			22		

V. Locating Bed and Securing Placement						
A. Documentation reflects that client/family was appropriately assisted in locating a facility suitable to client's needs	6					
B. Documentation reflects that SA or Medicaid eligibility is confirmed or family is assisted in making payment arrangements	6	____	____			
1. prior to placement				10		
C. Documentation reflects that client/family was assisted in planning for and facilitating admissions process as needed:						
1. Assistance in planning for or moving the client	6	____	____			
2. Assistance with admissions procedures	6					
SUBTOTALS	24			10		

	QUALITY POINTS			TIMELINESS POINTS		
	Avail.	Applic.	Earned	Avail.	Applic.	Earned
VI. Post-Placement Adjustment (Low or High Intensity)						
A. Documentation reflects assessment of client's adjustment	6					
B. Documentation reflects provision or facilitation of adjustment services	10					
C. *Reviews and Updates*						
1 Quarterly Review is documented	2	____	____			
a. within time frame set by agency				2	____	____
2. Service Plan is updated to reflect client's progress and significant changes in the client's situation	4	____	____			
3. Dss-5027 is updated for any status changes	2	____	____			
a. by the following Quarterly Review				2	____	____
b. copy sent to client notifying of changes within time frames in Vol. VI, Chapt. 2, Sec. 8080 of Family Services Manual				2		
SUBTOTALS	24			6		

VII. Placement Service Termination						
A. Documentation reflects that final contacts are made with significant persons to assess need for continued service or termination	6					
B. Documentation reflects the reason for termination of Adult Placement Services and the continuation and/or addition of other services	6	____	____			
1. required documentation/dictation is current within timeframe of agency				2		
C. Dss-5027 (notice of termination and systems data) is						
1. complete	2	____	____			
2. accurate	2	____	____			
3. (copy) sent to the client at least ten working days prior to the date of termination				3		
SUBTOTALS	16			5		

TOTALS	172			52		

DECLARATION OF RESIDENT'S RIGHTS

EVERY RESIDENT SHALL HAVE THE FOLLOWING RIGHTS:

1. TO BE TREATED WITH RESPECT, CONSIDERATION, DIGNITY, AND FULL RECOGNITION OF HIS OR HER INDIVIDUALITY AND RIGHT TO PRIVACY.

2. TO RECEIVE CARE AND SERVICES WHICH ARE ADEQUATE, APPROPRIATE, AND IN COMPLIANCE WITH RELEVANT FEDERAL AND STATE LAWS AND RULES AND REGULATIONS.

3. TO RECEIVE UPON ADMISSION AND DURING HIS OR HER STAY A WRITTEN STATEMENT OF THE SERVICES PROVIDED BY THE FACILITY AND THE CHARGES FOR THESE SERVICES.

4. TO BE FREE OF MENTAL AND PHYSICAL ABUSE, NEGLECT, AND EXPLOITATION.

5. EXCEPT IN EMERGENCIES, TO BE FREE FROM CHEMICAL PND PHYSICAL RESTRAINT UNLESS AUTHORIZED FOR A SPECIFIED PERIOD OF TIME BY A PHYSICIAN ACCORDING TO CLEAR AND INDICATED MEDICAL NEED.

6. TO HAVE HIS OR HR PERSONAL AND MEDICAL RECORDS KEPT CONFIDENTIAL AND NOT DISCLOSED WITHOUT THE WRITTEN CONSENT OF THE INDIVIDUAL OR GUARDIAN, WHICH CONSENT SHALL SPECIFY TO WHOM THE DISCLOSURE MAY BE MADE, EXCEPT AS REQUIRED BY APPLICABLE STATE OR FEDERAL STATUTE OR REGULATION OR BY THIRD PARTY CONTRACT. IT IS NOT THE INTENT OF THIS SECTION TO PROHIBIT ACCESS TO MEDICAL RECORDS BY THE TREATING PHYSICTAN EXCEPT WHEN THE INDIVIDUAL OBJECTS IN WRITING. RECORDS MAY ALSO BE DISCLOSED WITHOUT THE WRITTEN CONSENT OF THE INDIVIDUAL TO AGENCIES, INSTITUTIONS OR INDIVIDUALS WHICH ARE PROV EMERGENCY MEDICAL SERVICES TO THE INDIVIDUAL. DISCLOSURE OF INFORMATION SHALL BE LIMITED TO THAT WHICH IS NECESSARY TO MEET THE EMERGENCY.

7. TO RECEIVE A REASONABLE RESP.JNSE TO HIS OR HER REQUESTS FROM THE FACILITY ADMINISTRATOR AND STAFF.

8. TO ASSOCIATE AND COMMUNICATE PRIVLSTELY AND WITHOUT RESTRICTION WITH PEOPLE AND GROUPS OF HIS OR HER OWN CHOICE ON HIS OR HER OWN OR THEIR INITIATIVE AT ANY REASONABLE HOUR.

9. TO HAVE ACCESS AT ANY REASONABLE HOUR TO A TELEPHONE WHERE HE OR SHE MAY SPEAK PRIVATELY.

10. TO SEND AND RECEIVE MAIL PROMPTLY AND UNOPENED, UNLESS THE RESIDENT REQUESTS THAT SOMEONE OPEN AND READ MAIL, AND TO HAVE ACCESS AT HIS OR HER EXPENSE TO WRITING INSTRUMENTS, STATIONERY, AND POSTAGE.

11. TO BE ENCOURAGED TO EXERCISE HIS OR HER RIGHTS AS A RESIDENT AND CITIZEN, AND TO BE PERMITTED TO MAKE COMPLAINTS AND SUGGESTIONS WITHOUT FEAR OF COERCION OR RETALIATION.

12. TO HAVE AND USE HIS OR HER OWN POSSESSIONS WHERE REASONABLE AND HAVE AN ACCESSIBLE, LOCKABLE SPACE PROVIDED FOR SECURITY OF PERSONAL VALUABLES. THIS SPACE SHOULD BE ACCESSIBLE ONLY TO THE RESIDENT, THE ADMINISTRATOR, OR SUPERVISOR IN CHARGE.

13. TO MANAGE HIS OR HER PERSONAL NEEDS FUNDS UNLESS SUCH AUTHORITY HAS BEEN DELEGATED TO ANOTHER IF AUTHORITY TO MANAGE PERSONAL NEEDS FUNDS HAS BEEN DELEGATED TO THE FACILITY, THE RESIDENT HAS THE RIGHT TO EXAMINE THE ACCOUNT AT ANY TIME.

14. TO BE NOTIFIED WHEN THE FACILITY IS ISSUED A PROVISIONAL LICENSE OR NOTICE OF REVOCATION OF LICENSE BY THE NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES AND THE BASIS ON WHICH THE PROVISIONAL LICENSE OR NOTICE OF REVOCATION OF LICENSE WAS ISSUED. THE RESIDENT'S RESPONSIBLE FAMILY MEMBER OR GUARDIAN SHALL

ALSO BE NOTIFIED.

15. TO HAVE FREEDOM TO PARTICIPATE BY CHOICE IN ACCESSIBLE COMMUNITY ACTIVITIES AND IN SOCIAL, POLITICAL, MEDICAL, AND RELIGIOUS RESOURCES AND TO HAVE FREEDOM TO REFUSE SUCH PARTICIPATION.

16. TO RECEIVE UPON ADMISSION TO THE FACILITY A COPY OF THIS SECTION.

ARTICLE 6

§131E-117 HEALTH CARE FACILITIES §131E-117

Part B. Nursing Home Patients' Bill of Rights.

§ 131E-117. Declaration of patient's rights.

All facilities shall treat their patients in accordance with the provisions of this Part. Every patient shall have the following rights:

(1) To be treated with consideration, respect, and full recognition of personal dignity and individuality;

(2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;

(3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on filed in the facility and available for inspection;

(4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of. Medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed ac acknowledgements by the patient, shall be retained by the facility in the patient's file;

(5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or third party payment contract;

(6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need;

(7) To receive from the administrator or staff of the facility a reasonable response to all requests;

(8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and unopened, unless the patient is unable to open and, read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage;

(9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs in the event that, the facility manages the patient's financial affairs, it shall have an accountant available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days' notice.

(10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room;

(11) To enjoy privacy in the patient's room;

(12) To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient's personal behalf or that of others to the facility's staff the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination;

(13) To not be required to perform services for the facility with out personal consent and the written approval of the at tending physician;

(14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable;

(15) To not be transferred or discharge from a facility except for medical reasons, the pi s own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days' advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's medical record;

(16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1989. C.75.)

Part B. Nursing Home Patients' Bill of Rights.

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(2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;

(3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection;

(4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgements by the patient, shall be retained by the facility in the patient's file;

(5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or third party payment contract;

(6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need;

(7) To receive from the administrator or staff of the facility a reasonable response to all requests;

(8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage;

(9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency

has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days' notice.

(10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room;

(11) To enjoy privacy in the patient's room;

(12) To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient's personal behalf or that of others to the facility's staff, the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination;

(13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician;

(14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable;

(15) To not be transferred or discharged from a facility except for medical reasons, the patient's own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days' advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's medical record;

(16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1989, c. 75.)

Editor's Note. — Session Laws 1989, c. 75, which amended this section, provided in s. 2: "This act is effective on October 1, 1989, and shall not apply to pending litigation."

Effect of Amendments. — The 1989 amendment, effective October 1, 1989, added subdivision (16). As to the applicability of this amendment, see the Editor's Note.

Health Care Power of Attorney

A Guide for North Carolinians

Introduction

You have the right to control the decisions about your medical care. To make these decisions, you must be competent and able to communicate. What happens if you are unable to make decisions about your medical care? North Carolina law provides two methods for making your wishes known in advance. You may use a *living will* to tell your doctors that you do not want to be kept alive by extraordinary medical treatment or by artificial nutrition or hydration if you are terminally and incurably ill or if you are in a persistent vegetative state. You may use a *health care power of attorney* to appoint someone to make your medical decisions if you should become unable to make them yourself. This publication explains how to use a health care power of attorney.

For more information about living wills, read the North Carolina Cooperative Extension Service publication, The Living Will, HE-364.

Health Care Power of Attorney

What is it? A health care power of attorney is a document that allows someone to make medical decisions for you if you cannot make them yourself. You must sign the document in the presence of two qualified witnesses, and it must be notarized. The form provided by Section 32A-25, North Carolina General Statutes, is duplicated at the end of this publication. Other forms may be used as long as they comply with the requirements of the statute. Your lawyer can explain how to use the appropriate forms.

Who may make a health care power of attorney? You must be 18 years old or older, and you must be able to make and communicate health care decisions.

Who may be appointed? You may appoint any competent person who is 18 years old or older and who is not providing health care to you for money. The person you appoint is called your *health care agent.*

How much authority does it give your health care agent? You may give your health care agent the same power and authority as you have yourself to make your medical decisions. This includes the power to consent to your doctor giving, withholding or stopping any medical treatment, service or diagnostic procedure, including life-sustaining procedures.

You also may limit your health care agent's power. To make sure that your health care agent understands how you want everything handled, you may provide directions or guidelines as part of your health care power of attorney. However, limits on your health care agent's authority may reduce his or her ability to make necessary medical decisions on your behalf. Also, a too-complicated health care power of attorney may leave your doctor unsure as to which decisions may be made by your health care agent.

In addition to making your health care decisions, you may authorize your health care agent to donate your body for medical purposes, to donate your organs, to authorize an autopsy, and to dispose of your remains.

When is it effective? Your health care power of attorney is effective when a doctor states in writing that you lack sufficient understanding or capacity to make or communicate health care decisions. You may name the doctor or doctors you want to make this determination. If the doctors you name are unavailable, the doctor taking care of you may make this determination.

How is a health care power of attorney revoked? You may revoke your health care power of attorney at any time, so long as you are able to make and communicate your medical care decisions. The revocation may be in writing or by any means that you are able to communicate your intent to revoke to your doctor and health care agent. Also, you revoke a health care power of attorney by signing another health care power of attorney. Revocation is effective only after you have notified your doctor and each named health care agent. Finally, your death revokes your health care power of attorney.

North Carolina Cooperative Extension Service
North Carolina State University

What happens if your health care agent is unable or unwilling to act? What happens if your health care agent dies or becomes sick or incapacitated? What if he simply refuses to act? To avoid this problem, you may want to name substitute health care agents. If none of the people you have named can serve, your health care power of attorney will have no legal effect.

How does a health care power of attorney work if you have given someone a durable power of attorney? A durable power of attorney is a document used to give someone the legal authority to act on your behalf. A general durable power of attorney gives someone (called your "attorney-in-fact") broad powers to handle your affairs, including your property and finances. How does the health care power of attorney work if you have given someone a durable power of attorney?

You may include a health care power of attorney in your durable power of attorney. If you choose this method, the same person who has authority to handle your financial and other personal affairs will have the authority to make your health care decisions. One document covers everything.

Or, you may choose to name a health care agent in a separate health care power of attorney. A health care power of attorney does not affect the nonhealth care powers granted to your attorney-in-fact under a general durable power of attorney. However, if you give health care powers to both your attorney-in-fact and to your health care agent, your health care agent's power is superior.

For more information about durable powers of attorney, read the North Carolina Cooperative Extension publication, Legal Authority, HE-363.

How does a health care power of attorney work if the court appoints a guardian? If the court appoints a guardian of the person (someone to take care of your physical needs) or a general guardian (someone to take care of both you and your property), your health care power of attorney will cease to be effective. To protect your choice of health care agent, you may use your health care power of attorney to recommend that your health care agent be appointed as your guardian of the person if you are declared legally incompetent. *For more information about guardianship, read the North Carolina Cooperative Extension publication,* Legal Authority, HE-363.

Conclusion

A health care power of attorney is the best assurance that your medical care will be handled the way you want if you become unable to make these decisions yourself. Simply telling your family what you want done is not enough. Someone needs the legal right to make these decisions for you. Choose your health care agent carefully. He or she will have the right to make life and death decisions on your behalf. Make sure your health care agent understands your wishes. For guidance and more information, ask your attorney.

Prepared by Carol A. Schwab
Member of the North Carolina Bar
Family Resource Management Specialist, North Carolina Cooperative Extension Service

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HE-387

Health Care Power of Attorney

(Notice: This document gives the person you designate your health care agent broad powers to make health care decisions for you, including the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. This power exists only as to those health care decisions for which you are unable to give informed consent.

This form does no: impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will have to use due care to act in your best interests and in accordance with this document. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures with your health care agent.

Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.)

1. Designation of health care agent.

I, _____, being of sound mind, hereby appoint

Name: _____

Home Address: _____

Home Telephone Number_____

Work Telephone Number_____

As my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

A. Name: _____

Home Address: _____

Home Telephone Number_____

Work Telephone Number_

B. Name: _____

Home Address: _____

Home Telephone Number_____

Work Telephone Number_____

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of appointment.

(Notice: This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)

Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians (You may include here a designation of

your choice, including your attending physician or any other physician. You may also name two or more physicians, if desired both of whom must make this determination before the authority granted to the health care agent becomes effective.)

_____

_____

_____

3. General statement of authority granted.

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

B. To employ or discharge my health care providers;

C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;

D. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.

E. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

> I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

F. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

G. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

4. Special provisions and limitations.

(Notice: The above grant of power is intended to be as broad as possible so that your health care agent will have authority to make wry decisions you could make to obtain or terminate wry type of health care. If you wish to limit the scope of your health care agent’s powers, you may do so in this section.)

In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations (Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious belief, or unacceptable to you for any other reason.):

_____

_____

_____

5. Guardian provision....

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security.

6. Reliance of third parties on health care agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

7. Miscellaneous provisions.

A. I revoke any prior health care power of attorney.

B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.

C. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.

D. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

8. Signature of principal.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

Signature of Principal_____ Date_____

9. Signatures of Witnesses.

I hereby state that the Principal, _____ being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will., I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a

nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

Witness: _____ Date: _____

Witness: _____ Date: _____

STATE OF NORTH CAROLINA
COUNTY OF_____

CERTIFICATE

I, _____, a Notary Public for _____ County, North Carolina, hereby certify that _____ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____ sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, no an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____ day of _____, 19___

Notary Public_____

My Commission Expires:

(A copy of this form should be given to your health care agent and any alternate named in this power of attorney, and to your physician and family members.)

I, _____, agree to act as health care agent for _____ pursuant to this health care power of attorney.

This the _____ day of _____, 19

_____

The Living Will

A Guide for North Carolinians **Revised September 1991**

1. Introduction.

A. Definition: A living will is a declaration that you desire to die a natural death. You do not want extraordinary medical treatment or artificial nutrition or hydration used to keep you alive if there is no reasonable hope of recovery.

B. The patient's rights: You have a basic right to control the decisions about your medical care, including the decision to have extraordinary means or artificial nutrition or hydration withdrawn or withheld if your condition is fatal or if you are in a persistent vegetative state.

1. If you are competent and able to communicate, you may tell your doctor that you do not want extraordinary means or artificial nutrition or hydration used to keep you alive if there is no hope of recovery.

2. What happens if you are not competent or able to communicate this decision?

a. You may decide ahead of time with a living will.
b. If you do not have a living will, someone else may have to decide for you.

II. A living will is a legal document.

A. Statutory requirements: You must follow certain requirements to make your living will legally effective.

1. You must be 18 years old and of sound mind when you sign your living will.
2. Your living will must contain specific statements.
3. You must sign your living will and have it properly witnessed and certified.

B. Required statements:

1. You must declare that, depending upon your instructions, you do not want your doctor to use extraordinary means or artificial nutrition or hydration to keep you alive if your condition is terminal and incurable or if you are in a persistent vegetative state.

2. You must state that you know your living will allows your doctor to withhold or stop extraordinary medical treatment or artificial nutrition or hydration, in accordance with your instructions.

3. You must instruct the doctor what you want done if your condition is terminal or incurable or if you are in a persistent vegetative state. You may make these choices in your living will.

a. If your condition is terminal and incurable, your living will may instruct your doctor to do the following:

(1) to withhold or stop extraordinary means only, or

(2) to also withhold or stop artificial nutrition or hydration.

b. If you are in a persistent vegetative state, your living will may instruct your doctor to do the following:

(1) to withhold or stop extraordinary means only, or

(2) to also withhold or stop artificial nutrition or hydration.

C. Properly signed and witnessed:

1. You must sign your living will in the presence of two witnesses:

a. who are not related to you or your spouse;

b. who will not inherit property from you, either under your will or under the laws that determine who will get your property if you do not have a will;

c. who are not your doctor, your doctor's employees, or the employees of your hospital, nursing home or group-care home; and

d. who do not have a claim against you.

2. A notary public or a clerk or assistant clerk of superior court must certify your living will.

D. A copy of a living will, which is provided by Section 90-321, North Carolina General Statutes, is duplicated at the end of this publication. The law authorizing this form was effective October 1, 1991. You should ask your attorney's advice before modifying the statutory form.

III. How does a valid living will work?

A. Your properly signed, witnessed, and certified living will may be used in the following manner.

1. If your doctor determines that your condition is

a. terminal, and

b. incurable, or

c. diagnosed as a persistent vegetative state; and

2. A second doctor confirms this opinion;

3. Your doctor may withhold or stop extraordinary medical treatment or artificial nutrition or hydration, in accordance with your instructions.

B. Artificial nutrition or hydration describes the use of feeding tubes to give someone food or water.

C. Extraordinary medical treatment includes any medical procedure which artificially postpones the moment of death by supporting or replacing a vital bodily function.

D. You are considered to be in a persistent vegetative state if you have had a complete loss of self-aware cognition (you are a vegetable), and you will die soon without the use of extraordinary medical treatment or artificial nutrition or hydration.

IV. How do you revoke your living will?

A. If you change your mind, you may revoke your living will by destroying the original and all copies of your living will. Be sure to tell your doctor that you have revoked your living will.

B. You may revoke your living will by communicating this desire to your doctor. You may use any means available to communicate your intent to revoke. You're mental or physical condition is not considered, so you do not need to be of sound mind. Someone acting on your behalf may also tell your doctor that you want to revoke your living will. Revocation is effective only after your doctor has been notified.

V. Where should you store your living will?

A. Suggestions:

1. Keep the original in a place where you or your family members may find it easily. Some lawyers suggest that you sign several copies and have each one witnessed and certified. Then, you may give an original to each of the appropriate people. However, if you change your mind and revoke your living will, make sure that you destroy all the original copies.

2. Carry a wallet card stating you have a living will.

3. Give a copy of your living will to your health care agent. You may appoint a health care agent with a health care power of attorney or with a general durable power of attorney. Ask your lawyer for details. For more information about health care agents, read the North Carolina Cooperative Extension publication, Health Care Power of Attorney, HE-387.

4. Give a copy of your living will to your doctor

5. Give a copy of your living will to your family.

B. Do not put your living will in a lock box or safety deposit box -- it may be found too late.

VI. What happens if you do not have a living will?

A. If you are comatose and there is no reasonable expectation that you will return to consciousness, or if you are mentally incapacitated, and

B. Your doctor determines that your condition is:

1. terminal, and
2. incurable, or
3. diagnosed as a persistent vegetative state; and

C. Another doctor confirms this diagnosis in writing; and

D. A vital bodily function must be restored or supported by extraordinary means; or

E. Your life must be supported by artificial nutrition or hydration;

F. The extraordinary means or artificial nutrition or hydration may be withheld or stopped,

G. With the permission of:

1. your health care agent,
2. your guardian,
3. your spouse, or
4. the majority of your parents and children.

H. If you do not have a living will, your family is burdened with the decision. Your family may not be able to agree on what action to take. The lack of decision by your family may lengthen your suffering and increase your medical bills. A living will removes the decision from your family's shoulders and makes the decision yours.

VII. What is the effect of your living will if you move out of North Carolina?

A. Not all states have laws providing for living wills, and different states may have different laws on living wills. Your North Carolina living will may not be valid in another state. If you move to a new state, check with an attorney for local law on living wills.

B. If you spend a lot of time in other states, you may want to sign a living will for each state.

NORTH CAROLINA COUNTY OF _____

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:

(Initial any of the following, as desired):

___If my condition is determined to be terminal and incurable, I authorize the following:

___My physician may withhold or discontinue extraordinary means only.

___In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

___If my physician determines that I am in a persistent vegetative slate, I authorize the following:

___My physician may withhold or discontinue extraordinary means only.

___In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

This the _____ day of _____ -

Signature: _____

I hereby state that the declaring, _____, being of sound mind signed the above declaration in my presence and that I am not related to the declaring by blood or marriage and that I do not know or have a reasonable expectation that I-would be entitled to any portion of the estate of the declaring under any existing will or codicil of the declaring or as an heir under the Intestate Succession Act if the declaring died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declaring is a patient or an employee of a nursing home or any group-care home where the declaring resides. I further state that I do not now have any claim against the declaring.

Witness: _____

Witness: _____

CERTIFICATE

I, _____, Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for _____ County hereby certify that _____, the declaring, appeared before me and swore to me and to the witnesses in my presence that this instrument is his/her Declaration Of A Desire For A Natural Death, and that he/she had willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____and _____, witnesses, appeared before me and swore that they witnessed _____, declaring, sign the attached declaration, believing him/her to be of sound mind; and also swore that at the time they witnessed the declaration (I) they were not related within the third degree to the declaring or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declaring upon the declarant's death under any will of the declaring or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (iii) they were not a physician attending the declaring or an employee of an attending physician or an employee of a health facility in which the declaring was a patient or an employee of a nursing home or any group-care home in which the declaring resided, and (iv) they did not have a claim against the declaring. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the _____ day of _____, 19_.

_____

Clerk (Assistant Clerk) of Superior Court or Notary Public
(Circle one as appropriate) for the County of

_____

131E-110 and G.S. 131D-2. (1989, c. 403, s. 1.)

§ 143B-181.22. State/Regional Long-Term Care Ombudsman; confidentiality.

The identity of any complainant, resident on whose behalf a complaint is made, or individual providing information on behalf of the resident or complainant relevant to the attempted resolution of a complaint is confidential and may be disclosed only with the express permission of the person. The information produced by the process of complaint resolution may be disclosed by the State Ombudsman or Regional Ombudsman only if the identity of any such person is not disclosed by name or inference. If the identity of any such person is disclosed by name or inference in such information, the information may be disclosed only with his express permission. If the complaint becomes the subject of a judicial proceeding, the investigative information may be disclosed for the purpose of the proceeding. (1989, c. 403, s. 1.)

§ 143B-181.23. State/Regional Long-Term Care Ombudsman; prohibition of retaliation.

No person shall discriminate or retaliate in any manner against any resident or relative or guardian of a resident, any employee of a long-term care facility, or any other person because of the making of a complaint or providing of information in good faith to the State Ombudsman or Regional Ombudsman. (1989, c. 403, s. 1.)

§ 143B-181.24. Office of State/Regional Long-Term Care Ombudsman; immunity from liability.

No representative of the Office shall be liable for good faith performance of official duties. (1989, c. 403, s. 1.)

§ 143B-181.25. (Effective until January 1, 1995) Office of State/Regional Long-Term Care Ombudsman; penalty for willful interference.

Willful or unnecessary obstruction with the State or Regional Long-Term Care Ombudsman in the performance of his official duties is a general misdemeanor. (1989, c. 403, s. 1.)

Section Set Out Twice. — The section above is effective until January 1, 1995. For the section as amended effective January 1, 1995, see the following section, also numbered § 143B-181.25.

§ 143B-181.25. (Effective January 1, 1995) Office of State/Regional Long-Term Care Ombudsman; penalty for willful interference.

Willful or unnecessary obstruction with the State or Regional Long-Term Care Ombudsman in the performance of his official duties is a Class 1 misdemeanor. (1989, c. 403, s. 1; 1993, c. 539, s. 1039.)

Section Set Out Twice. — The section above is effective January 1, 1995. For the section as in effect until January 1, 1995, see the preceding section, also numbered § 143B-181.25.

Editor's Note. — Session Laws 1993, c. 539, which amended this section, in s. 1359 provides: "Prosecutions for offenses committed before the effective date of this act are not abated or affected by this act, and the statutes that would be applicable but for this act remain applicable to those prosecutions." Section 1359 of Chapter 539 provides that the act becomes effective January 1, 1995.

Effect of Amendments. — The 1993 amendment, effective January 1, 1995, and applicable to offenses occurring on or after that date, substituted "Class 1" for "general."

§§ 143B-181.26 through 143B-181.49: Reserved for future codification purposes.

§ 131D-31. Domiciliary home community advisory committees.

(a) Statement of Purpose. — It is the intention of the General Assembly that community advisory committees work to maintain the intent of the Domiciliary Home Residents' Bill of Rights within the licensed domiciliary homes in this State. It is the further intent of the General Assembly that the committees promote community involvement and cooperation with domiciliary homes to ensure quality care for the elderly and disabled adults.

(b) Establishment and Appointment of Committees. —

(1) A community advisory committee shall be established in each county which has at least one licensed domiciliary home, shall serve all the homes in the county, and shall work with each of these homes for the best interests of the residents. In a county which has one, two, or three homes for the aged and disabled, the committee shall have five members.

(2) In a county with four or more homes for the aged and disabled, the committee shall have one additional member for each home for the aged and disabled in excess of three, up to a maximum of 20 members. In each county with four or more homes for the aged and disabled, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each domiciliary home in the county. Each member must serve on at least one subcommittee.

(3) In counties with no homes for the aged and disabled, the committee shall have five members. Regardless of how many members a particular community advisory committee must have, at least one member of each committee shall be a person involved in the area of mental retardation.

(4) The boards of county commissioners are encouraged to appoint the Domiciliary Home Community Advisory Committees. Of the members, a minority (not less than one-third, but as close to one-third as possible) must be chosen from among persons nominated by a majority of the chief administrators of domiciliary homes in the county. If the domiciliary home administrators fail to make a nomination within 45 days after written notification has been sent to them requesting a nomination, such appointments may be made without nominations. If the county commissioners fail to appoint members to a committee by July 1, 1983, the appointments shall be made by the Assistant Secretary on Aging, Department of Human Resources, no sooner than 45 days after nominations have been requested from the domiciliary home administrators, but no later than October 1, 1983. In making his appointments, the Assistant Secretary shall follow the same appointment process as that specified for the County Commissioners.

(c) Joint nursing and Domiciliary Home Community Advisory Committees. — Appointment to the Nursing Home Community Advisory Committees shall preclude appointment to the Domiciliary Home Community Advisory Committees except where written approval to combine these committees is obtained from the Assistant Secretary on Aging, Department of Human Resources. Where such approval is obtained, the Joint Nursing and Domiciliary Home Community Advisory Committee shall have the membership required of Nursing Home Community Advisory Committees and one additional member for each home for the aged and disabled present in the county. In counties with no homes for the aged and disabled, there shall be one additional member for every four domiciliary homes in the county. In no case shall the number of members on the Joint Nursing and Domiciliary Home Community Advisory Committee exceed 25. Each member shall exercise the statutory rights and responsibilities of both Nursing Home Committees and Domiciliary Home Committees. In making appointments to this joint committee, the county commissioners shall solicit nominations from both nursing and domiciliary home administrators for the appointment of approximately (but no more than) one-third of the members.

(d) Terms of Office. — Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a two- or three-year term at the

county commissioners' discretion to ensure staggered terms of office.

(e) Vacancies. — Any vacancy shall be filled by appointment of a person for a one-year term. If this vacancy is in a position filled by an appointee nominated by the chief administrators of domiciliary homes within the county, then the county commissioners shall fill the vacancy from persons nominated by a majority of the chief administrators. If the domiciliary home administrators fail to make a nomination by registered mail within 45 days after written notification has been sent to them requesting a nomination, such appointment may be made without nominations. If the county commissioners fail to fill a vacancy, the vacancy may be filled by the Assistant Secretary on Aging, Department of Human Resources no sooner than 45 days after the commissioners have been notified of the appointment or vacancy.

(f) Officers. — The committee shall elect from its members a chair, to serve a one-year term.

(g) Minimum Qualifications for Appointment. — Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by the committee, or employee or governing board member of a home served by the committee, or immediate family member of a resident in a home served by the committee may be a member of that committee. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Division of Aging, Department of Human Resources.

(h) Training. — The Division of Aging, Department of Human Resources, shall develop training materials, which shall be distributed to each committee member. Each committee member must receive training as specified by the Division of Aging prior to exercising any power under G.S. 131D-32. The Division of Aging, Department of Human Resources, shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.

(i) Any written communication made by a member of a domiciliary home advisory committee within the course and scope of the member's duties, as specified in G.S. 131D-32, shall be privileged to the extent provided in this subsection. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements and communications do not amount to intentional wrongdoing.

To the extent that any domiciliary home advisory committee or any member thereof is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance. (1981, c. 923, s. 1; 1983, c. 88, s. 1; 1987, c. 682, s. 2.)

Editor's Note. — Session Laws 1983, c. 88, which amended this section, in s. 3, provided: "Sec. 3. Those facilities licensed pursuant to G.S. 130-9(e)(5) [now repealed] are not covered by this act but are covered by G.S. 130-9.5 [now repealed]." For present provisions relating to the licensure of nursing homes and the nursing home patients' bill of rights, see Parts A and B of Article 6 of Chapter 131E (§ 131E-100 et seq.).

§ 131D-32. Functions of domiciliary home community advisory committees.

(a) The committee shall serve as the nucleus for increased community involvement with domiciliary homes and their residents.

(b) The committee shall promote community education and awareness of the needs of aging and disabled persons who reside in domiciliary homes, and shall work towards keeping the public informed about aspects of long-term care and the operation of domiciliary homes in North Carolina.

(c) The committee shall develop and recruit volunteer resources to enhance the quality of life for domiciliary home residents.

(d) The committee shall establish linkages with the domiciliary home administrators and the county department of social services for the purpose of maintaining the intent of the Domiciliary Home Residents' Bill of Rights.

(e) Each committee shall apprise itself of the general conditions under which the persons are residing in the homes, and shall work for the best interests of the persons in the homes. This may include assisting persons who have grievances with the home and facilitating the resolu-

tion of grievances at the local level. The names of all complaining persons and the names of residents involved in the complaint shall remain confidential unless written permission is given for disclosure. The committee shall notify the enforcement agency of all verified violations of the Domiciliary Home Residents' Bill of Rights.

(f) The committee or subcommittee may communicate through the committee chair with the Department of Human Resources, the county department of social services, or any other agency in relation to the interest of any resident.

(g) Each committee shall quarterly visit the homes for the aged and disabled it serves. For each official quarterly visit, a majority of the committee members shall be present. A minimum of three members of the committee shall make at least one visit annually to each family care home and group home for developmentally disabled adults present in the county. In addition, each committee may visit the domiciliary homes it serves whenever it deems it necessary to carry out its duties. In counties with subcommittees, the subcommittee assigned to a home shall perform the duties of the committee under this subsection, and a majority of the subcommittee members must be present for any visit. When visits are made to group homes for developmentally disabled adults, rules concerning confidentiality as adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall apply.

(h) The individual members of the committee shall have the right between 10:00 a.m. and 8:00 p.m. to enter the facility the committee serves in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited to members of the subcommittee which serves that home. A majority of the committee or subcommittee members must be present to enter the facility at other hours. Before entering any domiciliary home, the committee or members of the committee shall identify themselves to the person present at the facility who is in charge of the facility at that time.

(i) The committee shall prepare reports as required by the Department of Human Resources containing an appraisal of the problems of domiciliary care facilities as well as issues affecting long-term care in general. Copies of the report shall be sent to the board of county commissioners, county department of social services and the Division of Aging.

(j) Nothing contained in this section shall be construed to require the expenditure of any county funds to carry out the provisions herein. (1981, c. 923, s. 1; 1983, c. 88, s. 2; 1991, c. 636, s. 19(b).)

Editor's Note. — Session Laws 1983, c. 88, which amended this section, in s. 3, provided: "Sec. 3. Those facilities licensed pursuant to G.S. 130-9(e)(5) [now repealed] are not covered by this act but are covered by G.S. 130-9.5 [now repealed]." For present provisions relating to the licensure of nursing homes and the nursing home patients' bill of rights, see Parts A and B of Article 6 of Chapter 131E (§ 131E-100 et seq.).

Effect of Amendments. — The 1991 amendment, effective July 11, 1991, substituted reference to Mental Health, Developmental Disabilities, and Substance Abuse for reference to Mental Health, Mental Retardation, and Substance Abuse in subsection (g).

Part 14D. Long-Te m Care Ombudsman Program.

§ 143B-181.15. Long-Term Care Ombudsman Program/Office; policy.

The General Assembly finds that a significant number of older citizens of this State reside in long-term care facilities and are dependent on others to provide their care. It is the intent of the General Assembly to protect and improve the quality and care and life for residents through the establishment of a program to assist residents and providers in the resolution of complaints or common concerns, to promote community involvement and volunteerism in long-term care facilities, and to educate the public about the long-term care system. It is the further intent of the General Assembly that the Department of Human Resources, within available resources and pursuant to its duties under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001-3057g, ensure that the quality of care and life for these residents is maintained, that necessary reports are made, and that, when necessary, corrective action is taken at the Department level. (1989, c. 403, s. 1.)

§ 143B-181.16. Long-Term Care Ombudsman Program/Office; definition.

Unless the content clearly requires otherwise, as used in this Article:

(1) "Long-term care facility" means any skilled nursing facility and intermediate care facility as defined in G.S. 131A-(4) [131A-3(4)] or any domiciliary home as defined in G.S. 131D-20(2).

(2) "Resident" means any person who is receiving treatment or care in any long-term care facility.

(3) "State Ombudsman" means the State Ombudsman as defined by the Older Americans Act of 1965, as amended, who carries out the duties and functions established by this Article.

(4) "Regional Ombudsman" means a person employed by an Area Agency on Aging to carry out the functions of the Regional Ombudsman Office established by this Article. (1989, c. 403, s. 1.)

Editor's Note. — The reference in this section to § 131A-(4) was apparently intended to refer to § 131A-3(4).

§ 143B-181.17. Office of State Long-Term Care Ombudsman Program/Office; establishment.

The Secretary of Department of Human Resources shall establish and maintain the Office of State Long-Term Ombudsman in the Division of Aging. The Office shall carry out the functions and duties required by the Older Americans Act of 1965, as amended. This Office shall be headed by a State Ombudsman who is a person qualified by training and with experience in geriatrics and long-term care. The Attorney General shall provide legal staff and advice to this Office. (1989, c. 403, s. 1.)

§ 143B-181.18. Office of State Long-Term Care Ombudsman Program/State Ombudsman duties.

The State Ombudsman shall:

(1) Promote community involvement with long-term care provider and residents of long-term care facilities and serve as liaison between residents, residents' families, facility personnel, and facility administration;

(2) Supervise the Long-Term Care Program pursuant to rules adopted by the Secretary of the Department of Human Resources pursuant to G.S. 143B-10;

(3) Certify regional ombudsmen. Certification requirements shall include an internship training in the aging process, complaint resolution, long-term care issues, mediation techniques, recruitment and training of volunteers, and relevant federal, State, and local laws, policies, and standards;

(4) Attempt to resolve complaints made by or on behalf of individuals who are residents of long-term care facilities, which complaints relate to administrative action that may adversely af-

fect the health, safety, or welfare of residents;

(5) Provide training and technical assistance to regional ombudsmen;

(6) Establish procedures for appropriate access by regional ombudsmen to long-term care facilities and residents' records including procedures to protect the confidentiality of these records and to ensure that the identity of any complainant or resident will not be disclosed without the written consent of the complainant or resident or upon court order;

(7) Analyze data relating to complaints and conditions in long-term care facilities to identify significant problems and recommend solutions;

(8) Prepare an annual report containing data and findings regarding the types of problems experienced and complaints reported by residents as well as recommendations for resolutions of identified long-term care issues;

(9) Prepare findings regarding public education and community involvement efforts and innovative programs being provided in long-term care facilities; and

(10) Provide information to public agencies, and through the State Ombudsman, to legislators, and others regarding problems encountered by residents or providers as well as recommendations for resolution. (1989, c. 403, s. 1.)

§ 143B-181.19. Office of Regional Long-Term Care Ombudsman; Regional Ombudsman; duties.

(a) An Office of Regional Ombudsman Program shall be established in each of the Area Agencies on Aging, and shall be headed by a Regional Ombudsman who shall carry out the functions and duties of the Office. The Area Agency on Aging administration shall provide administrative supervision to each Regional Ombudsman.

(b) Pursuant to policies and procedures established by the State Office of Long-Term Care Ombudsman, the Regional Ombudsman shall:

(1) Promote community involvement with long-term care facilities and residents of long-term care facilities and serve as a liaison between residents, residents' families, facility personnel, and facility administration;

(2) Receive and attempt to resolve complaints made by or on behalf of residents in long-term care facilities;

(3) Collect data about the number and types of complaints handled;

(4) Work with long-term care providers to resolve issues of common concern;

(5) Work with long-term care providers to promote increased community involvement;

(6) Offer assistance to long-term care providers in staff training regarding residents' rights;

(7) Report regularly to the office of State Ombudsman about the data collected and about the activities of the Regional Ombudsman;

(8) Provide training and technical assistance to the community advisory committees; and

(9) Provide information to the general public on long-term care issues. (1989, c. 403, s. 1.)

§ 143B-181.20. State/Regional Long-Term Care Ombudsman; authority to enter; cooperation of government agencies; communication with residents.

(a) **(Effective until January 1, 1995)** The State and Regional Ombudsman may enter any long-term care facility and may have reasonable access to any resident in the reasonable pursuit of his function. The Ombudsman may communicate privately and confidentially with residents of the facility individually or in groups. The Ombudsman shall have access to the patient records of any resident, under procedures established by the State Ombudsman pursuant to G.S. 143B-181.18(6), provided that the medical and personal financial records pertaining to an individual resident may be inspected only with the permission of the resident or his legally appointed guardian, if any. Entry shall be conducted in a

manner that will not significantly disrupt the provision of nursing or other care to residents and if the long-term care facility requires registration of all visitors entering the facility, then the State or Regional Ombudsman must also register. Any State or Regional Ombudsman who discloses any information obtained from the patient's medical or personal financial records without a court order or without authorization in writing from the resident, or his legal representative, is guilty of a general misdemeanor.

(a) **(Effective January 1, 1995)** The State and Regional Ombudsman may enter any long-term care facility and may have reasonable access to any resident in the reasonable pursuit of his function. The Ombudsman may communicate privately and confidentially with residents of the facility individually or in groups. The Ombudsman shall have access to the patient records of any resident, under procedures established by the State Ombudsman pursuant to G.S. 143B-181.18(6), provided that the medical and personal financial records pertaining to an individual resident may be inspected only with the permission of the resident or his legally appointed guardian, if any. Entry shall be conducted in a manner that will not significantly disrupt the provision of nursing or other care to residents and if the long-term care facility requires registration of all visitors entering the facility, then the State or Regional Ombudsman must also register. Any State or Regional Ombudsman who discloses any information obtained from the patient's medical or personal financial records without a court order or without authorization in writing from the resident, or his legal representative, is guilty of a Class 1 misdemeanor.

(b) The State or Regional Ombudsman shall identify himself as such to the resident, and the resident has the right to refuse to communicate with the Ombudsman.

(c) The resident has the right to participate in planning any course of action to be taken on his behalf by the State or Regional Ombudsman, and the resident has the right to approve or disapprove any proposed action to be taken on his behalf by the Ombudsman.

(d) The State or Regional Ombudsman shall meet with the facility administrator or person in charge before any action is taken to allow the facility the opportunity to respond, provide additional information, or take appropriate action to resolve the concern.

(e) The State and Regional Ombudsman may obtain from any government agency, and this agency shall provide, that cooperation, assistance, services, data, and access to files and records that will enable the Ombudsman to properly perform his duties and exercise his powers, provided this information is not privileged by law.

(f) If the subject of the complaint involves suspected abuse, neglect, or exploitation, the State or Regional Ombudsman shall notify the county department of social services' Adult Protection Services section of the county department of social services, pursuant to Article 6 of Chapter 108A of the General Statutes. (1989, c. 403, s. 1; 1993 c. 539, s. 1038.)

Subsection (a) Set Out Twice. — The first version of subsection (a) set out above is effective until January 1, 1995. The second version of subsection (a) set out above is effective January 1, 1995.

Editor's Note. — Session Laws 1993, c. 539, which amended this section, in s. 1359 provides: "Prosecutions for offenses committed before the effective date of this act are not abated or affected by this act, and the statutes that would be applicable but for this act remain applicable to those prosecutions." Section 1359 of Chapter 539 provides that the act becomes effective January 1, 1995.

Effect of Amendments. — The 1993 amendment, effective January 1, 1995, and applicable to offenses occurring on or after that date, substituted "Class 1 for "general" preceding "misdemeanor" in the last sentence of subsection (a).

§ 143B-181.21. State/Regional Long-Term Care Ombudsman; resolution of complaints.

(a) Following receipt of a complaint, the State or Regional Ombudsman shall attempt to resolve the complaint using, whenever possible, informal technique of mediation, conciliation, and persuasion.

(b) Complaints or conditions adversely affecting residents of long-term care facilities that cannot be resolved in the manner described in subsection (a) of this section shall be referred by the State or Regional Ombudsman to the appropriate licensure agency pursuant to G.S. 131E-100 through

APPENDIX P

FUNDING SOURCES FOR ADULT PLACEMENT SERVICES

Division of Social Services

Social Services block Grant (SSBG)--primarily federal funds which may be used to provide Adult Placement Services to any adult determined to be in need of the service.

Division of Medical Assistance

Case Management Service for Adults At-Risk of Abuse, Neglect, or Exploitation-- when a person meets the criteria for At-Risk Case Management Services, and the activities which are needed are to locate, coordinate, and monitor a placement arrangement, some of these activities may be billable under Medicaid. For more information on this service, refer to the North Carolina Medicaid Special Bulletin of October 1992--Case management Services for Adults and Children At-Risk of Abuse, Neglect, or Exploitation.